

## **PRESENTER'S GUIDE**

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### **PAS: EMERGENCY ROOM PROCESSING**

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## LIST OF EFFECTIVE PAGES

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## **PAS: EMERGENCY ROOM PROCESSING**

### **Presenter's Guide Overview**

#### **I. THE CHCS TRAINING SYSTEM**

The CHCS Training System is composed of training documentation and the Training Database, which are designed to support classroom training for the presenter and students. For more complete class information, refer to the CHCS Class Descriptions, TC-[4]-0720<sup>1</sup> and TC-4-0729<sup>2</sup>.

The training documentation and Training Database are the basic tools for conducting CHCS training; however, you are the key to making the training sessions successful learning experiences for the students. Refer to the Facility Trainer Preparation class (Lesson 1: Teaching/Learning Strategies) for detailed information on presentation skills.

The following documents are used to teach this class:

- Presenter's Guide
- Student Guide
- Subsystem-Specific Reference Manual

The Training Database, also referred to as the Training Software, is designed to support directed training in conjunction with the Presenter's and Student Guides. The Training Database includes pre-positioned (previously entered) data that supports the specific CHCS functionality presented in these training materials. The Training Database contains all of the application software the students will use at their workcenters, and pre-positioned data to support all CHCS classes.

Because the pre-positioned data supports only the documented classes, the Training Database cannot be used for free practice or for demonstrations other than those outlined in the Presenter's Guides. Refer to the Facility Trainer Preparation class (Lesson 7: The Training Database) for more detailed information on the structure and refresh capability of the Training Database.

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<sup>1</sup> The middle digit changes according to the CHCS software version.

<sup>2</sup> Subject to revision.

## **II. TRAINING DOCUMENTATION OVERVIEW**

The training documentation for this CHCS class is composed of three different manuals: the Presenter's Guide, the Student Guide, and a subsystem-specific Reference Manual.

### **PRESENTER'S GUIDE**

The Presenter's Guide provides the lesson plans, class preparatory activities, and demonstration outlines you will need to present the specific CHCS class. It also contains copies of the Practices, the Master Practice, Evaluation Criteria, and the data cards for use with the Training Database. Graphics (figures) are provided as appropriate to support your class presentation.

The Presenter's Guide contains the following sections:

#### **Presenter's Guide Overview**

This section contains an overview of the CHCS training system; class-specific information; checklists of presenter activities before, during, and after class; and commonly asked questions. It lists two types of questions relating to the class presentation:

##### **Site-Specific Questions**

These are questions you will need to ask at every location where you teach this class, whether a site or regional training center. They generally deal with workflow procedures. Management representatives of the target audience can provide answers for site-specific issues. These answers may affect how the class materials are customized for use at the site.

##### **Other Questions Students Might Ask**

These are questions that students may generate during classroom training. Answers are provided for this type of question.

## **Section 1. Class Outline**

This section contains the actual class presentation material.

### **I. Introduction**

This subsection outlines purpose, specifications, and objectives.

### **II. Expanded Presentation**

This subsection contains detailed directions and explanations regarding the topics and activities covered in the class.

### **III. Brief Presentation**

This subsection contains a skeletal version of the Expanded Presentation. Detailed information is left out, and only the presentation steps are listed. This version of the presentation, edited slightly, becomes the Presentation for the Student Guide. You may choose to use this subsection for presenting the class once you become familiar with it.

### **IV. Closure**

This subsection discusses what the students have learned and how it fits with other training.

## **Section 2. Practices**

The practices include scenarios similar to those used in the presentation. In some classes, the scenarios are specific to a particular student group (e.g., target audience). Evaluation Criteria are provided.

## **Section 3. Master Practice**

The Master Practice is a cumulative activity for the students that addresses the objectives covered. You will evaluate the students' skill levels based upon their ability to complete this practice, using the Evaluation Criteria provided.

## **Section 4. Data Cards**

The data cards are used with the Training Database. They contain the data that should be entered to support the Presentation, Practices, and Master Practice. Data cards are provided for the presenter and 10 students. For some classes, there is enough pre-positioned data for two sessions of a class to be conducted concurrently, and the data cards are marked accordingly.

## **Section 5. Reference Materials**

This section contains class-specific supporting materials, such as output samples, sample reports, keyboard templates, Medication Instruction List for writing prescriptions, Procedure Flowcharts, and Quick Reference Guides. If certain functionalities use information or perform calculations supported by scientific literature, references to the literature are included herein.

## **Section 6. Transparencies**

This section contains transparency masters of figures and tables. The students do not receive this section.

## **Appendix A. Class Evaluation Forms**

This appendix contains evaluation forms to be completed at the end of every CHCS class. Refer to the Facility Trainer Preparation class (Lesson 5) for detailed explanations of each form and instructions on how to distribute the forms. Briefly, the Class Evaluation Forms are as follows:

### **Class Critique**

Students use this form to evaluate the class.

### **Student Attendance and Performance Summary**

Use this form to document student attendance and level of achievement in reference to the Master Practice.

## **STUDENT GUIDE**

The Student Guide is provided for classroom use. At the discretion of the site, the guides may be retained by the student when the class is over, or the guides may need to remain in the classroom for use by other sessions of the same class. Additional materials may be available to support the class presentation. These materials will often be a benefit at workcenters. Some of the materials will be reproduced and provided as handouts.

The Student Guide contains the following sections:

### **Student Guide Overview**

This section contains an overview of the Student Guide, class specifications, and conventions used in the documentation.

### **Section 1. Class Outline**

Slightly edited, this section is the same as in the Presenter's Guide. It contains the presentation objectives, topics, activities, and steps.

### **Section 2. Practices**

These are the same practices that appear in the Presenter's Guide; however, the Evaluation Criteria are not included in the Student Guide.

### **Section 3. Master Practice**

This is the same Master Practice that appears in the Presenter's Guide; however, the Evaluation Criteria are not included in the Student Guide.

### **Section 4. Data Cards**

This section contains all of the same data cards that appear in the Presenter's Guide.

## **Section 5. Reference Materials**

This section contains all of the Reference Materials that appear in the Presenter's Guide.

In addition to the Student Guide, students should be provided with a handout containing class-specific Quick Reference Guides extracted from the Reference Materials.

## **SUBSYSTEM REFERENCE MANUAL**

The Subsystem Reference Manual is designed to support and augment classroom training. Both the Presenter's Guide and the Student Guide are dependent upon use of the Reference Manual. Copies of this manual should be available to all students for use during classroom training. There will be additional copies available at the workcenters for the students to use when they begin using CHCS on the job.

The Reference Manual contains the following sections:

### **Section 1. Subsystem Overview**

### **Section 2. Menu Diagrams & Definitions**

This section contains menu diagrams for the entire subsystem, and definitions of every menu option in the diagrams.

The first part of this section is the Option Finder, where every menu option in the subsystem is listed alphabetically by option name (not synonym). The page number where the option definition is found is listed at the right margin, opposite the option name.

A diagram of the main subsystem menu immediately follows the Option Finder. Beginning on the page following this diagram, options on the main subsystem menu are briefly defined in the order they appear on the menu.

Options on the main subsystem menu that lead to additional menus are also diagrammed to show all menu layers. On a separate page, associated option definitions immediately follow each main option diagram, also in the order they appear on the successive menus.

### **Section 3. Procedure Flowcharts**

Flowcharts are a visual representation of the steps required to complete a procedure.

#### **Section 4. Quick Reference Guides**

This section contains “at a glance” information, including option or action definitions, screen displays, entry path, and other “need to know” information, for commonly used options and actions. Most of the guides are specific to the subsystem; however, some of the guides in each Reference Manual apply to all subsystems. The titles of these common Quick Reference Guides all begin with “CHCS.”

The guides are displayed sideways on the paper so that the sites can have the guides bound into a pocket-size quick reference for users.

#### **Section 5. Subsystem Glossary**

This section contains CHCS and subsystem terminology and definitions. The terms are arranged alphabetically for easy reference.

#### **Section 6. Sample Output Reports**

This section contains sample copies of subsystem reports. You may want to refer students to this section during class as you discuss the various reports available.

### **III. CLASS SPECIFICATIONS**

#### **PAS: Emergency Room Processing**

**COURSEWARE**

**NUMBERS:** TC-4.5-0336/TC-4.5-0337

**OVERVIEW:**

This class teaches students how to check-in and check-out Emergency Room patients, view patient appointment history, print Emergency Room forms and reports, and change Emergency Room parameters.

**CLASS LENGTH:**

4 hours

**TARGET AUDIENCE:**

Emergency Room Personnel (Clerks, Supervisors)

**OBJECTIVES:**

- Check-in a patient to the Emergency Room and print the SF558.  
Practice 1
- Register a Jane or John Doe patient.  
Practice 2
- Check-out a patient from the Emergency Room.  
Practice 3
- Update a patient's Emergency Room encounter information.  
Practice 4
- View past and future appointments, and Wait List requests for a specified patient and family member.  
Practice 5
- Reprint the SF558.  
Practice 6
- Generate a partial register.  
Practice 7
- Disposition all patients from the Emergency Room.  
Practice 8
- Discuss Emergency Room parameters.  
No practice.

**PREREQUISITES:**

ORT: CHCS Orientation

Supervisors:

PAS: Profiles, Templates, and Tables

## **PAS: Emergency Room Processing (continued)**

### **RECOMMENDED**

**CLASSES:** None

## **CLASS PRESENTATION OVERVIEW**

PAS: Emergency Room Processing is designed for selected supervisors and clerks working in the Emergency Room, so that students can observe options in use, and hear related discussions of the functionality before performing the Practices and Master Practice. Students should log on to the system when instructed, and remain logged on until the class has been completed. Scenarios have been written to help the students relate the functionality to their real-life workflow and activities.

The sequence of the class presentation is very important. Some activities are based on successful completion of prior objectives (i.e., for a user to enter updated patient Emergency Room encounter information, the user must first check-in the patient). The Practices and Master Practice should also be used in the sequence in which they have been written.

Allow a 10-minute break after approximately every 50 minutes of class time.

Ask students to complete and turn in the Class Critique along with the Master Practice when their requirements for the class have been met (e.g., at the end of a module).

Remember to check the Class Presentation Checklist for items applicable to all CHCS training classes.

## **CLASSROOM TRAINING MATERIALS**

The following materials are specific to the presentation of this class:

- PAS: Emergency Room Processing Presenter's Guide
- PAS: Emergency Room Processing Student Guide
- Patient Appointment and Scheduling Reference Manual

Refer to the Preclass Checklist for equipment and supporting materials that may be needed.

## IV. CONVENTIONS

### GENERIC CONVENTIONS

- designates objectives. The activities following the solid box support that objective.
- designates subobjectives. The activities following the open box support that subobjective.

**ALL CAPS AND BOLD** text at the left margin indicates a topic. A topic appears within the text of an objective or subobjective and can include information that is independent or supportive of an objective or subobjective.

**Initial Caps and Bold** text at the left margin indicates a level 1 subtopic. A level 1 subtopic appears within the text of a topic. It includes information that is supportive of the topic.

**Initial Caps and Bold** text at one indent indicates a level 2 subtopic. A level 2 subtopic appears within the text of a level 1 subtopic and includes information that is supportive of the level 1 subtopic.

**Initial Caps and Bold** text at two indents indicates a level 3 subtopic. A level 3 subtopic appears within the text of a level 2 subtopic and includes information that is supportive of the level 2 subtopic.

- ▲ designates a procedure. Numbered steps following the solid triangle support that procedure.

**Bullets (•)** with an action verb indicate activity steps.

Following a prompt, text in **ALL CAPS AND BOLD** indicates specific data to be entered (typed or selected from the screen) by the student. This specific (or constant) data is usually the same for all students or for the activity.

Variable data is represented by **[text in square brackets]**. Variable data can be data provided on the appropriate data card, or it can be data that you choose to support the scenario. This variable data is different for each student.

The complete menu path is always included each time a menu option is accessed, starting at the subsystem primary menu. The synonym for the menu where the last objective or activity ended is listed in **bold**. If the last activity was a practice, the lowest menu common to both the practice and the current objective is listed in **bold**.

**Primary Menu → ME → IOP**

*Scenarios* appear in italics for easy recognition.

## **V. CLASS CHECKLISTS**

### **PRECLASS CHECKLIST**

- \_\_\_\_\_ Determine the target audience and associated specialties.
- \_\_\_\_\_ Review Class Outline, Practices, and Data Cards. Note that the Class Outline is broken into four sections: Introduction, Brief Presentation, Expanded Presentation, and Closure.
- \_\_\_\_\_ Review Subsection VI of the Presenter's Guide Overview (Commonly Asked Questions) for site issues and questions commonly asked by students.
- \_\_\_\_\_ Contact the management representatives of the target audience to determine how they plan to incorporate CHCS into the workflow for each of the specialty areas.
- \_\_\_\_\_ Customize the class presentation to be site- or specialty-specific. Be prepared to discuss the manner in which the site has chosen to deal with a particular activity.
- \_\_\_\_\_ Reproduce graphics to use in class as viewgraphs, as appropriate.
- \_\_\_\_\_ Reproduce the Quick Reference Guides from Section 5 for all students attending this class.
- \_\_\_\_\_ Reproduce the Class Critique (see Appendix A) for distribution after completion of the Master Practice.
- \_\_\_\_\_ Determine Area, Username, and the availability of Training Database and class-specific data.
- \_\_\_\_\_ Determine if the following equipment is available and functioning properly:
  - Overhead Projector
  - VT Series Terminal (for the presenter)
  - VT Series Terminals (one for each student)
  - LA Series Companion Printer(s)
  - Electrohome Projection Monitor or LCD Display Tablet
  - Other \_\_\_\_\_

**PRECLASS CHECKLIST** (continued)

- \_\_\_\_\_ Check the site policy on whether students are allowed to retain their Student Guides. If not, duplicate the paper-and-pencil tests as handouts or instruct the students to write their answers on the blank paper provided.
  
- \_\_\_\_\_ Determine that the following training materials are available for use:
  - Presenter's Guide
  - Student Guides (one copy per training station)
  - Subsystem Reference Manual (one copy per training station)
  - Quick Reference Guide handout
  - Additional reference materials (as applicable)
  - Pens/Pencils
  - Blank paper (as applicable for note-taking or practices)
  - Chalk/Greaseboard (whiteboard) pens
  - Other \_\_\_\_\_
  
- \_\_\_\_\_ Place the following at each student's terminal:
  - Student Guides
  - Subsystem Reference Manual
  - Quick Reference Guide handout
  - Additional reference materials (as applicable)
  - Class Critique
  - Other \_\_\_\_\_

## **CLASS PRESENTATION CHECKLIST**

- \_\_\_\_\_ At the beginning of the class, show the students how to use the Student Guide and Subsystem Reference Manual. Encourage them to use the materials during class.
- \_\_\_\_\_ Encourage students to take notes. Inform students that blank paper is available, or they may write on their Quick Reference Guide handout.
- \_\_\_\_\_ Remind students about secondary menu options (covered in ORT: CHCS Orientation).
- \_\_\_\_\_ Have students log on when indicated in the Class Outline.
- \_\_\_\_\_ Remind students of the preferred method for accessing patient records at Select Patient prompts. Explain that, due to restrictions of the Training Database, during training they may be required to use patient name instead.
- \_\_\_\_\_ During class, refer students to the appropriate sections of the Reference Manual as indicated in the Class Outline.
- \_\_\_\_\_ Direct students to perform scenario-based practices at the appropriate times noted in the Class Outline. Note that some classes offer different practice scenarios that address specific specialty areas.
- \_\_\_\_\_ Remember to allow students to take a 10-minute break for every 50 minutes of class time.

## **POSTCLASS CHECKLIST**

- \_\_\_\_\_ Direct students to complete the Master Practice.
- \_\_\_\_\_ Direct students to complete the Class Critique.
- \_\_\_\_\_ Distribute additional handouts, as applicable.
- \_\_\_\_\_ Remind students to take the Quick Reference Guide handout with them and any additional reference materials distributed at the beginning of the class.
- \_\_\_\_\_ Inform students that the copy of the Reference Manual remains in the classroom, and that another copy of the Reference Manual will be located at the workcenter for extended help or information after training is completed.
- \_\_\_\_\_ Remind students to use the Online Users Manual as needed at their workcenter.
- \_\_\_\_\_ Give the attendance roster and all samples of student performance to the Facility Training Coordinator when the class is over.

## VI. COMMONLY ASKED QUESTIONS

The following is a list of issues that might affect the way students use CHCS. Once it is determined how students will deal with specific activities, the training materials can be customized to reflect these issues.

### SITE-SPECIFIC QUESTIONS:

- What is the preferred method for identifying patients in CHCS at this facility?

**Answer:** When training students at each site, extensively use the site-preferred method for identifying and selecting patients.

- What are the site's active parameters? Who determines the parameters at this site?
- Who determines which PAS users or clerks have the authority to register new patients into the CHCS at this site?

### OTHER QUESTIONS STUDENTS MIGHT ASK:

- What is the difference between the Cost Pool code and the MEPRS code?

**Answer:** The Cost Pool code collects direct or indirect operating expenses for reassignment to work center accounts and ultimately to final operating expense accounts.

The Cost Pool code allocates bulk costs to a work center based on the proportion of workload accomplished by the subaccounts in the locations. For example: The OB/GYN Clinic has a Cost Pool code of BCXA. (The third character in any Cost Pool code is an "X.") Two MEPRS codes exist within the OB/GYN Clinic against which workload is assigned (i.e., BCAA and BCBA). At the end of the reporting period, total workload is determined for the MEPRS codes BCAA and BCBA, and the total proportion of workload for each code is determined. Costs assigned against the Cost Pool code BCXA are apportioned out to the two MEPRS codes based on the workload completed for the previous month.

The Cost Pool code concept was originally provided for pharmacy. Pharmacies issue drugs to stock in the clinics. Many times, clinics share the same facilities. Rather than have two supply lockers, they share and pro-rate costs.

**OTHER QUESTIONS STUDENTS MIGHT ASK:** (continued)

- Can we add a new patient to CHCS from anywhere, or do we need to be in the Registration Menu, then the Mini Registration option?

**Answer:** A patient can be entered into the CHCS from anywhere the system presents the Select Patient prompt. After entering the new patient name, the system searches for her/him. If unable to locate information on this patient, the system asks if you want to add this person as a new patient. If you respond YES, you are presented with Mini Registration displays that allow you to enter registration data on this patient.

Once you register this patient, you can check-in him/her for facility or Emergency Room processing and/or treatment.

- Can any PAS user or clerk register a patient, or is this task restricted to selected users and clerks?

**Answer:** CHCS has a special feature that allows PAS users and clerks to register a new patient into the system. Without this special feature, an ampersand (&) inserted in the PAS user's Fileman access, the user would be unable to register a new patient into CHCS. Which PAS users and clerks can register new patients is site-defined.

- How will a PAS user know if she/he can register patients into CHCS?

**Answer:** In any PAS option where the Select Patient (Name) prompt is displayed, enter the new patient's name (patient is not currently registered at your facility) using the following format: last name,first name.

If the system response to the entry of the new patient's complete name (i.e., SHANKS,ALICIA A) is:

Select Patient: ??

or

Select Patient:

then you do not have the special feature that allows you to register patients into the CHCS.

**OTHER QUESTIONS STUDENTS MIGHT ASK:** (continued)

If the system response to the entry of the new patient's name is:

Are you adding [**patient last name, first name**] as a new PATIENT  
(the [n]th)? Y

then you do have the special feature that allows you to register patients into the CHCS.

- Emergency Room personnel maintained a manual record of patients seen for one day because the CHCS was down. The next day, this information was entered into the system when the CHCS was again operational. How can this antedated patient encounter information be entered into the CHCS reflecting the date of the actual encounter(s) instead of today's date?

**Answer:** Prior to selecting the Emergency Room Menu option that will allow you to enter Emergency Room patient encounter information, select the Activity Date and Emergency Room Clinic Edit (AER) option. This option allows you to enter or change the Emergency Room clinic and/or activity date. Changing the activity date informs the computer that all information you will be entering next is for the Emergency Room encounter that occurred on the new activity date. Once you have entered or changed the Emergency Room clinic and/or activity date, the Emergency Room Menu is redisplayed. Next, enter the antedated patient information using other appropriate Emergency Room Menu option(s).

**Note:** Remember, when you have finished entering antedated patient information, reaccess the AER option to change the activity date back to today's date.

# **PAS: EMERGENCY ROOM PROCESSING**

## **Section 1 Class Outline**

## **PAS: EMERGENCY ROOM PROCESSING**

### **Section 1. Class Outline**

#### **I. INTRODUCTION**

Welcome to Emergency Room Processing.

The purpose of this class is to teach Emergency Room personnel how to check-in and check-out Emergency Room patients, view patient appointment history, print Emergency Room forms and reports, and change Emergency Room parameters using the Patient Appointment and Scheduling (PAS) Subsystem of CHCS.

This class is scheduled to last approximately 4 hours.

The target audience is:

- Emergency Room Personnel (Clerks, Supervisors)

Prerequisites include:

- ORT: CHCS Orientation

Supervisors:

- PAS: Profiles, Templates, and Tables

There are no recommended classes.

#### **OVERVIEW OF EMERGENCY ROOM PROCESSING**

The activities in this class will be to check-in and check-out Emergency Room patients, register an Emergency Room patient including a Jane or John Doe patient, view patient appointments, update a patient's Emergency Room encounter form and Emergency Room parameters, and print the SF558. Students will be given a Practice after observing the demonstration of the functionality, and a Master Practice at the end of the class.

Practices will follow demonstration or lecture. A Master Practice will be given at the end of the class to demonstrate proficiency in the objectives presented.

## **DISCUSS OBJECTIVES**

- Check-in a patient to the Emergency Room and print the SF558.
- Register a Jane or John Doe patient.
- Check-out a patient from the Emergency Room.
- Update a patient's Emergency Room encounter information.
- View past and future appointments and Wait List requests for a specified patient and family member.
- Reprint the SF558.
- Generate a partial JCAHO control register.
- Disposition all patients from the Emergency Room.
- Discuss Emergency Room parameters.

## **II. EXPANDED PRESENTATION**

### **INTRODUCE THE PATIENT APPOINTMENT AND SCHEDULING (PAS) SYSTEM MENU**

- Log on to CHCS and access the PAS System Menu.

The PAS System Menu is the primary menu for PAS-related functions using CHCS.

### **INTRODUCE THE PATIENT APPOINTMENT AND SCHEDULING REFERENCE MANUAL**

A reference manual is available at each terminal for use in the classroom.

- The manual is also available at your workcenter.
- All menu definitions are contained in the manual.
- Refer to the Patient Appointment and Scheduling Reference Manual for applicable menu diagrams and definitions and procedural flowcharts.
- Enter ??? (to access the menu option descriptions online).

### **INTRODUCE THE PAS EMERGENCY ROOM MENU**

- Access the Emergency Room (EM) Menu on the PAS System Menu.

#### **PAS System Menu → EM**

- Describe the PAS System Menu options.

## ■ CHECK-IN A PATIENT TO THE EMERGENCY ROOM AND PRINT THE SF558

**Scenario:** *A visitor collapses in the lobby of the hospital and is brought to the ER. She is not registered at this facility, so you must register her using the Mini Registration option, then check-in the patient.*

The Emergency Room Menu option is located on the PAS System Menu. Selecting this option presents you with a brief series of prompts to the Emergency Room Menu. From this one menu, you can select all the options required in Emergency Room (ER) processing. During the Emergency Room Processing class, you will be working from this menu.

Your facility may have one or more ERs. An ER Profile is created for each ER at your facility, and is accessible through the Emergency Room Profiles Menu (EER) option. In the ER profile, the Is This An Emergency Room? field indicator is set to YES. To the Composite Health Care System (CHCS), this identifies your clinic location as an ER. PAS considers patient encounters in an ER as Walk-In appointments for that ER.

If you first logged on to the system and selected an option from the Emergency Room Menu, the system prompts you for an ER clinic and activity date. The clinic and activity date entries establish an active ER clinic and an active ER activity date used for the ER processes that follow. During your use of ER Processing options, you are not prompted for an ER clinic or activity date again unless you return to the PAS System Menu and select/reselect the Emergency Room Menu.

This lesson assumes that you are working in only one division. If you are working in one division, and are then assigned to work in another, you must obtain access to work in both divisions.

The first two objectives/demonstrations of this lesson explain how to check-in ER patients in the CHCS. The patients that are checked into an ER may be:

- Registered at the facility
- Unregistered at the facility
- Jane/John Doe patients (unable to communicate registration information).

PAS provides options on the Emergency Room Menu that allow you to process patients in any of these situations.

The New ER Patient Enter (NER) option on the Emergency Room Menu is used to check-in ER patients. This option establishes an appointment record for the patient in the active ER clinic on the active ER activity date. The appointment status is automatically set to Walk-In.

If the patient is already registered at your facility, you can use the NER option to update that existing registration, then check the patient into the ER. If the patient is not registered at your facility, the NER option is used to register and check-in the patient to the ER.

If the patient is a Jane or John Doe, the NER option is used to create a patient record for a DOE,JANE or DOE,JOHN; register this unknown patient; and check-in the patient to the ER.

Options on the Registration Menu can be used before or after using the NER option to edit patient information, register a new patient, or assign a tentative name for a Jane/John Doe to enter information about the ER encounter.

- Access the New ER Patient Enter (NER) option on the Emergency Room Menu.

PAS System Menu → **EM** → NER

- Refer to Quick Reference Guide: Patient Lookup.
- Select Clinic: **ER11**

Explain:

Since you have just logged on to the system, the prompts - Enter Clinic - and - ER Activity Date - are displayed.

Enter the name of the ER clinic for which you wish to enter information.

- Enter ER activity date: <**Return**>

Explain:

Press <Return> to accept the default of today as the ER activity date. Normally, today's date is used as the activity date.

However, if the system has been down or an encounter must be backdated, you would enter the date of actual encounter, if not today's date.

**Note:** At other times when information for entry must be backdated or entered for another ER clinic at the facility, if any, the clinic or activity date can be changed using the Activity Date and ER Clinic Edit (AER) option.

## **REGISTER THE PATIENT INTO YOUR FACILITY**

Register the unregistered patient into CHCS before checking in the patient to the ER.

You also have the option of entering a Jane or John Doe Registration. Enter an ampersand (&) <Shift> <7>. The procedure to register and check-in a Jane or John Doe is covered in the next demonstration.

After entering a registered patient's name, the system displays the patient's family member prefix (FMP), Social Security number (SSN), birthdate, sex, and command security code (if applicable). The system then requires patient name verification: OK? YES//.

For the registered patient, the Demographics Display screen is displayed. The patient's registration data can then be edited, if necessary.

If the registered patient has been inadvertently identified as a duplicate patient (i.e., the patient has been registered twice under different names), the system issues a message stating which name to use. When you confirm the patient name, you will be confirming the patient that the system has selected.

If any family member (patients with the same sponsor SSN) has had changes in demographic data, a screen with the next of kin's name and demographic fields to update is displayed. Below the next of kin information is the prompt - Do you want to move information to [next of kin's name]? YES//. You can press <Return> to accept the default, or, if you do not wish to have the information transferred to the next of kin, enter NO.

If there is more than one family member for this sponsor, you will be prompted to update the registration data for each family member. However, in this scenario, the patient to be checked in to your ER is not registered into your facility. Therefore, before this patient, who is her own sponsor, can be checked in, she must first be registered into your facility.

Start the registration process by entering the unregistered patient's identifier at the prompt.

Since this patient is not registered at this facility, the system accesses Mini Registration and allows registration of the patient at this time.

Point out to the students that Mini Registration can also be accessed through the Emergency Room Menu, Registration Menu (RER), Option 8 (Mini Registration) (i.e., ER → RER → 8).

## REVIEW PROPER PATIENT LOOKUP PROCEDURES

It is critical to identify patients in CHCS correctly.

Small differences in the entry of a patient name can create a duplicate patient entry.

Since duplicate records in the system can significantly impact patient safety, reduce system response time, and are difficult to correct, the following three-step method of patient lookup is strongly recommended prior to registering a new patient:

First Step: Enter the first letter of the patient's last name and the last four digits of the sponsor's SSN.

Second Step: Enter the sponsor's full SSN.

Third Step: Enter the patient's last name.

These three steps will be followed for this demonstration.

- Enter Patient Name: **S6101** (SHANKS,ALICIA A)

Explain:

This is the first step in the Patient Lookup Procedure.

Patients already in the system with a last name beginning with S (in this case) and whose last four SSN digits are 6101 are displayed as a selection list.

Review the list carefully. If the patient information for any of the listed patients matches information provided by the person currently requesting service, that person is already registered in the system.

If no patients with a last name beginning with S and whose last four SSN digits are 6101 are registered, the system returns two question marks (??) and repeats the prompt to select patient.

When no match is found using the first step, try the second step.

- Enter Patient Name: **611616101** (SHANKS,ALICIA A)

Explain:

This is the second step (i.e., entering the sponsor's full SSN).

Enter the SSN as one long nine-digit number without spaces or dashes.

The system searches for any patients already registered whose SSN is 611616101.

If information for one or more patients is displayed, check the display closely. If one of the patients listed matches the person requesting service, the person is already registered on the system.

If the system returns two question marks (??) and repeats the prompt to select patient name, try the third step.

- Enter Patient Name: **SHANKS** (SHANKS,ALICIA A)

Explain:

When a person's last name only is entered at a prompt to select patient name, the system searches and displays a selection list of all registered patients with that last name.

Again, check the display carefully. If none of the patients on the selection list match the person requesting service, return to the prompt to select patient name. Use proper format to enter the person's full name and proceed with the registration.

- Enter Patient Name: **SHANKS,ALICIA A**

Explain:

The correct format for entering a patient name in CHCS is:

SHANKS,ALICIA A

No space is left between the comma and the first name, and the middle initial does not include a period.

- Confirm that you are adding SHANKS, ALICIA A as a new Patient: **Y**

Explain that if you decide not to add this patient, enter N(O) instead of Y(ES) at the prompt.

- Enter Sponsor Name: **spacebar**, then **<Return>**

Explain:

Since the patient is her own sponsor, you can avoid typing in the sponsor name incorrectly by pressing the spacebar, then <Return> to re-enter the last patient name that you entered into CHCS (SHANKS,ALICIA A).

If the patient is his or her own sponsor, you must still enter the patient's name as the sponsor name.

If the sponsor is also new to the facility, you must register the sponsor first.

The Sponsor - Initial Information screen is displayed.

- Enter Sponsor FMP: **20**

Explain:

The Family Member Prefix (FMP) for the sponsor is 20.

Enter a double question mark (??) to display a picklist of FMPs.

## **DISCUSS THE HELP WINDOWS**

A popup window is displayed on the screen under the following conditions: a double question mark (??) was entered at the prompt, invalid data is entered, or verification that the information being added to the system is needed.

### **Discuss Displaying Help by Entering ??**

When ?? is entered at a prompt, a popup window displays on the screen containing information relevant to responding to the prompt.

Some examples of help text are as follows:

THE ANSWER MUST BE 3-30 CHARACTERS IN LENGTH

This field defines which Location Group for an IV Room will contain the IV orders that are forwarded to it from another IV Room.

This free text field identifies the IV location Group Name.

When more help text is available than the information presented in the help window, the (M)ore help action is displayed in the bottom portion of the help window.

## **Discuss Displaying the List of Valid Entries**

When the prompt can be responded to from a list of valid entries, the (L)ist of values action is displayed in the bottom portion of the help window.

If a plus sign (+) is displayed at the top or bottom of the list, use the up-arrow and down-arrow keys to display additional items on the list.

When the item to be selected in response to the prompt is displayed, use the up-arrow and down-arrow keys to position the cursor at the desired item and press <Select>.

## **Discuss the Keyboard Help Feature**

To display the keyboard help for special key functions press <PF1>, <Help>.

The keyboard functions are used to delete information from a field, move the cursor forward or backward through the fields on the screen, move to the previous or next screen, etc.

Pressing <Return> clears the keyboard help from the screen.

- Enter Sponsor DOB: **10 OCT 1960**

Explain that DOB stands for date of birth.

- Enter Sponsor SSN: **611-61-6101**

Explain:

Enter this sponsor's SSN with dashes (i.e., 611-61-6101).

If the SSN is unknown, enter P to display a pseudo SSN.

The first digit of the pseudo SSN is 8.

As soon as the SSN entry is completed, the system erases the SSN from view and asks you to verify the SSN entry.

The cursor moves to the Verify SSN field.

- Re-enter Sponsor SSN: **611-61-6101**

Explain:

The system asks that you enter the patient SSN twice. This is a confirmation device to reduce duplicate patient entries.

The two SSN entries must match before the system allows you to continue with the registration.

If the two SSN entries do not match, you will be asked to re-enter the SSN two more times.

- Enter Sponsor Patient Category (PATCAT): **A11**, then select USA AD Enlisted  
Explain that this is a required field.

## **DISCUSS THE HELP WINDOWS**

A popup window is displayed on the screen under the following conditions: a double question mark (??) was entered at the prompt, invalid data is entered, or verification that the information being added to the system is needed.

- File the data.

Explain:

With this information, a DEERS check is now automatically processed.

CHCS is integrated with the Department of Defense (DOD) Enrollment Eligibility Reporting System (DEERS). This system determines eligibility for health care. After searching the DEERS database, CHCS provides you with information describing the patient's eligibility for health care service. The DEERS Eligibility Data Screen displays after an individual eligibility check.

## **DISCUSS THE ACTION BAR ON THE DEERS ELIGIBILITY SCREEN**

The following options display on the DEERS Eligibility Data screen action bar:

- |                          |  |
|--------------------------|--|
| (V)iew more DEERS data   | – View additional data received from DEERS including CHAMPUS dental information.   |
| (H)istorical DEERS       | – View historical DEERS eligibility information.                                   |
| (O)verride Ineligibility | – Enter an override code if the patient's Direct Care eligibility is NOT ELIGIBLE. |
| (P)rint                  | – Print all eligibility information, including the historical data, if available.  |

- (C)ontinue – Continue with the process from which you entered the DEERS eligibility check.

The system searches the DEERS database, then displays the appropriate DEERS eligibility message at the bottom of the window. For this demonstration, the patient is ineligible and the prompt -Patient Ineligible. Enter override to continue. - displays.

- Press <**Return**> to accept the default to override the ineligibility.

The prompt - Do you want to override the DEERS Ineligibility and continue? NO// - is displayed in the lower section of the screen.

- Override the DEERS Ineligibility and continue: **YES**

Explain:

Press <Return> to accept the default not to override the DEERS ineligibility and to terminate the registration of this patient.

Enter YES to override the DEERS ineligibility, if applicable, for this patient, and continue the registration process. A list of override options is then displayed.

Enter the appropriate DEERS override code.

- Enter the DEERS Ineligibility Override Code: **2**

Explain:

For this demonstration, select option 2 - Presented valid DD Form 1172 and valid ID card - as the appropriate override code.

Enter ?? to display a list of override codes.

- Press <**Return**> to continue.

Explain that if the patient is found to be eligible, or the ineligibility status has been overridden, the system next displays the Mini Registration screen. The screen is divided by patient and sponsor information. The system displays the patient name.

The Mini Registration screen is partially filled with data entered in previous steps.

The cursor is in the Home Phone field. Press <Return> to advance the cursor through the data fields for data entry. When data is not required,

press <Return> to exit the field without an entry. Use the up-arrow key to move the cursor in reverse through the data fields.

The PATCAT and Sex fields are required. For the active duty sponsor, the Rank and Station/Unit fields are also required information. The remainder of the patient/sponsor data fields are optional (i.e., this data is helpful, but not necessary for a patient to be registered). However, you should enter data in all fields, if possible.

- Enter Home Phone Number: **(619)555-4938**

Explain:

Enter the patient's home phone number.

This is an optional field.

- Enter Work Phone Number: **(619)555-9991**

Explain:

Enter the patient's work phone number.

This is an optional field.

- Enter Patient Address: **1212 MAGNOLIA STREET**

Explain:

Enter the patient's home address.

This is an optional field.

- Enter Patient Sex: **FEMALE**

Explain:

Enter the patient's gender.

This is a required field.

- Enter Zip Code: **92111**

Explain:

Enter the Zip Code for the patient's home address.

The City and St/Cntry fields are automatically entered.

- Enter Service: **<Return>**

Explain:

The service branch of the sponsor is automatically entered. The system derived this information from the previous PATCAT entry.

- Enter SSN: **<Return>**

Explain:

The sponsor's SSN is automatically entered from a previous screen.

- Enter Command Sec: **PRP**

Explain:

This is not a required field; however, it is important to complete this field if the sponsor is designated as a member of one of the following security programs:

- Personnel Reliability Program (PRP)
- Presidential Support Program (PSP)
- Sensitive Compartmented Information (SCI).

The information contained in this field will flag the system to list this patient on the daily Command Security Report.

The Command Security Report lists any designated active-duty patient who had an appointment the previous day.

More information on completing this field may be obtained by entering ?? while the cursor is in the Cmd Sec field.

- Enter Patient Rank: **SSG**

Explain:

Enter the patient's rank.

Enter ?? is this field to display a valid list of ranks/paygrades used in this system.

- Enter Sponsor Station/Unit: **FORT EUSTIS**

Explain:

If the system cannot locate the name of the Station/Unit (duty station) that you entered within its database files, you will be prompted to use it as is. However, it is highly recommended that a valid Station/Unit is used whenever possible.

- Use as is: **YES**
- Enter Duty Address: **2200 FORT EUSTIS BLVD.**

Explain:

Enter the sponsor's duty address.

This is an optional field.

- Enter Zip Code: **23604**

Explain:

Enter the Zip Code from the patient's duty address.

The City and St/Cntry fields are automatically entered.

- Enter Duty Phone Number: **<Return>**

Explain that this field is the automatically entered with the sponsor's work phone number previously entered.

- Enter DSM: **<Return>**

Explain that this is the sponsor's Defense Switching Network (DSN) number, or press <Return> to bypass this optional field.

- Enter O/P Rec Loc: **MEDICAL RECORDS FILE ROOM**

Explain that you can enter an outpatient record location.

- Enter O/S Rec Loc: **<Return>**

Explain that if a record is not stored in a location defined in the Hospital Location file, you should enter a location comment using 3-65 characters describing, in detail, the location where it is stored.

- Enter Primary Phy: **<Return>**

Explain:

Enter the name of the primary physician assigned to this patient, or if not known currently, press <Return> to exit this field.

Enter ?? in this field to display a list of physicians who work at your facility.

- Enter Reg Comment: **<Return>**

Explain that you can enter a comment affecting the registration of this patient (3-40 characters) or press <Return> to exit this field.

- Enter Patient wants to be an organ donor: **Y**
- File the data.
- Enter/Edit Allergy Information? NO// **Y**

Explain that you can press <Return> to accept the default or enter Y(ES) to edit the patient's allergy data. If a Y(ES) is entered in this field, the system displays the Patient Allergies screen.

- Enter at Allergy: **BARBITURATES**

Explain:

Allergy information is site defined, and may be a medication. If an allergy is not specifically defined, you may enter OTHER, then enter a specific allergy comment.

Allergy information is very important because it indicates to CHCS that a patient has allergies which may endanger them if a particular procedure is performed or drug administered.

You can enter, for example, DIAGNOSTIC X-RAY MATERIALS as an allergy, then further define the type of contrast medium and the patient's allergic reaction.

This information is prominently displayed when a procedure to which the patient may be allergic is ordered, and is printed on the patient worksheet when the patient arrives for the procedure.

- Enter Comment: **MENTAL CONFUSION**

Explain:

The system allows you to enter additional or supplemental information for the allergy that you just entered (3-78 characters).

Enter information, or press <Return> to exit the field.

- Enter at Allergy: <**Return**>

Explain that you enter another allergy or press <Return> to exit the Enter/Edit Allergy option.

- File the data.
- Press <**Return**> to continue.

Explain that the Demographics Display screen is displayed.

## **DISCUSS THE TRANSFER OF REGISTRATION DATA TO FAMILY MEMBERS**

If a Mini Registration (new or a change) is performed for a patient who already has a family member(s) registered in CHCS, the prompt - Select Family Member to Move Demographic Data To - is then displayed.

A selection list of registered family members is displayed. Select the family member(s) whose appointment information you wish to display.

Use the down-arrow key to position the cursor next to the desired family member(s).

When the cursor is positioned, press <Select>.

Point out the asterisk (\*) that appears next to the selected family member(s).

Explain that you can deselect a category by pressing <Select> again.

When all selections have been marked, activate the selections by pressing <Return>.

The prompt allows you to transfer the personal data that you have just entered for this patient to other family members.

**EXAMPLE:**

You have just entered a new patient into CHCS who has other family members registered at your facility. The address of the new patient is different from that listed for other family members. The system detects the difference in family addresses and presents this prompt for you to make changes to family member registration data, if desired.

The Mini Registration process is now complete. The Demographics Display screen is displayed. The action bar displays Select (F)ull, (M)ini, (N)ew Patient, (C)ontinue, or (Q)uit DEMOGRAPHICS: C//.

- Select the Continue action: **<Return>**

Explain:

Enter F to perform a complete or full registration of this patient, and to update other family member histories.

Enter M to edit the registration data again for this patient using the Mini Registration (abbreviated) option.

After editing the data, the system returns to the NER option to proceed with the ER processing.

Press <Return> to accept the Continue default, and the system returns to the NER screen without additional editing of patient data.

Registration is now complete, and the check-in process can be started.

The NER screen is displayed. You can now check-in the registered patient to the ER.

The NER screen has the following header information:

- Patient Appointment: [patient name]
- Name of Screen
- Patient
- FMP/SSN
- Category (i.e., active duty Navy).

The NER screen (body) contains the following informational fields:

- Arrival Date/Time
  - Chief Complaint
  - Method of Transit
  - Appointment Type
  - History Obtained From
  - Third Party Payer
  - Arrival Category
  - MEPRS Code.
- Enter Arrival Date/Time: **<Return>**

Explain:

As a time-saving device, the system displays the current date and time. Change the date/time, if necessary, by typing over the default information.

Once the check-in information is filed, this field cannot be edited.

This is a required field.

Press <Return> to accept the default of the current date/time as arrival date/time.

- Enter Chief Complaint: **CHEST PAIN**

Explain:

Enter the reason (3-75 characters) that the patient has arrived in the ER for treatment.

This is a required field.

- Enter Method of Transit: **POV** (PRIVATELY OWNED VEHICLE)

Explain:

Enter the method of transit by which the patient arrived at the ER.

Enter ?? to display a valid list of facility-defined methods of transit.

This is a required field.

- Select Appointment Type: EROOM: **<Return>**

Explain that you press <Return> to accept the default that the ER is the appointment type.

- Enter History Obtained From: **PATIENT**

Explain:

Enter information on who informed ER personnel of the circumstances and history for this patient's emergency (i.e., patient, mother of patient, grandfather of patient, etc.).

Enter ?? to display a valid list of persons and relatives who could provide patient history information.

- Select that there is no third party payer: **<Return>**

Explain that you enter YES to indicate there is a third party payer (a private insurance company that can be billed for this encounter), or press <Return> to accept the default that there is no third party payer.

- Enter Arrival Category: **EMERGENCY**

Explain that you enter one of the following choices as the arrival category:

- E for Emergency
- U for Urgent
- N for Non-urgent.

- Enter MEPRS Code: [MEPRS code]// **<Return>**

Explain:

Press <Return> to accept the default MEPRS code for this ER clinic.

Enter the correct MEPRS code if the default code is incorrect.

## **DISCUSS MEPRS CODES**

MEPRS codes determine which clinic is credited, for cost purposes, for this encounter.

The Medical Expense Performance Reporting System (MEPRS) is a cost accounting process to determine the true cost of direct medical care to include amount of work, direct and indirect expenditures, and time/salary expenses of all hospital personnel.

Workload data for inclusion into MEPRS is collected from CHCS.

To differentiate between workload data collected from the various clinics and hospital locations, each medical care entity is assigned a permanent and unique MEPRS code (formerly referred to as a UCA code).

For CHCS use, the MEPRS code is a four-character group (i.e., for the Training Medical Center, the MEPRS code for the Cardiology Clinic is BACA).

The first character of the MEPRS code is the type of medical service primarily rendered by this medical entity as follows:

A = Inpatient

B = Outpatient (such as the Cardiology Clinic - BACA)

C = Dental

D = Ancillary Service (Radiology, pharmacy, etc.)

E = Administrative

F = Support

G = Readiness

Enter ?? to display a valid list of MEPRS codes.

The NER screen is replaced by the NER -- Continuation screen. The NER -- Continuation screen contains the same header information as the previous screen. The NER -- Continuation screen (body) contains the following informational fields:

- Next of Kin
- NOK-Phone

- Command Security
- Military Flying Status.
- Enter Next of Kin: **SHANKS,ALICE**

Explain:

This field may already be filled in with the Next of Kin (NOK) from the previous registration process.

If not, enter the NOK, if known, or press <Return> to exit the field without an entry.

- Enter NOK-Phone: **(619)555-6789**

Explain:

This field may already be filled in with the NOK telephone number from the previous registration process.

If not, enter the NOK telephone number, if known, or press <Return> to exit the field without an entry.

The NOK Telephone Number is 4-18 characters in the following format:  
Area Code-Prefix-Line Number-Extension.

- Enter Command Security: **<Return>**

Explain:

This field is related to the PATCAT field entry made during registration.

If the patient category entered for this patient during registration indicates that the patient is active duty military, then the system allows you to enter this field to enter information.

If the patient category indicates that this patient is not active duty military, the system will bypass this field.

If not entered during registration, it is important to complete this field if the active duty military patient is designated as a member of one of the following security programs:

- Personnel Reliability Program (PRP)
- Presidential Support Program (PSP)
- Sensitive Compartmented Information (SCI).

If the patient is a member of one of the above security programs, enter the name or abbreviation of the program in this field. If you entered this information during registration, the system will display it in this field.

If the active duty military patient is not a member of one of the above programs, press <Return> to exit this field without an entry.

- Enter Military Flying Status: **NO**

Explain:

This field is related to the PATCAT field entry made during registration.

If the patient category entered for this patient during registration indicates that the patient is active duty military, then the system allows you to enter this field to enter information.

If the patient category indicates that this patient is not active duty military, the system will bypass this field.

This field indicates whether or not the patient is in a Military Flying Status. Enter YES if the patient is in a Military Flying Status, or enter NO if the patient is not.

The NER screen redisplay.

- File the data.

Explain:

The message - ER # [nnnnnnn-nnnnn] assigned to this episode of care - is displayed. The message displays the number, for this ER, assigned to this encounter.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Report lists all ER encounters and the numbers assigned to them.

The ER # indicates the following information about this encounter:

- The first part is the year, month, and day (example: 920323 is 23 March 1992).
- The second part is the encounter number for this patient (example: 00004 is encounter 4, in this ER, for today).

The prompt - Print Encounter Form SF558 Work Sheet: YES// - is also displayed.

- Select to print the SF558 worksheet: **<Return>**

Explain:

The Encounter Form SF558 worksheet is an 80-column worksheet containing information just entered about the patient. The SF558, used to record the provider's handwritten comments, is the legal encounter form. It includes a patient signature line for receipt and understanding of the patient discharge instructions. It must be filed in the patient's record.

- Display Transparency 1: Sample SF558 Form.

Explain:

The YES or NO default displayed here is dependent on information entered in the Print SF558 Default in the NER Option field of the ER profile.

Enter NO if you choose not to print the SF558 at this time. It can be printed later using the SF558 Print (SER) option. Enter YES to print the SF558 now.

The Prompt - Device: [default device] - is displayed.

- Enter Device: [default device]// **<Return>**

Explain:

If a device has been entered in the Default Printer field, the device will be defaulted at this prompt.

If a default device is not displayed, enter a device name, or press **<Return>** to display the encounter form on the screen.

After the SF558 printing is completed, the system returns to the Emergency Room Menu.

## **STUDENT LOGON**

- Discuss data cards (i.e., username, password, area, access, and verify codes).
- Log on to the training software and use specified data.

**Practice 1** - Check-in an unregistered patient to the Emergency Room and print the SF558.

## ■ REGISTER A JANE OR JOHN DOE PATIENT

**Scenario:** *An unconscious female in her mid-twenties is brought to the ER. She is not registered at this facility, so you must register her using the John Doe Registration option. Then check her in to the ER.*

You will register a Jane or John Doe patient at this facility by entering specified information.

You will use the Jane or John Doe Registration action from the Registration Menu. The Jane or John Doe Registration option is used to register a patient whose identity is unknown.

There are two ways to register a Jane or John Doe patient:

- Access the Jane/John Doe Registration from the Registration Menu.
- Access the NER option and enter an ampersand (&) <Shift> <7> at the Patient Name prompt. This allows you to perform a Mini Registration for the patient before check-in to the ER.

It is important to register all patients since encounter information cannot be entered on unregistered patients. The system assigns a pseudo FMP/SSN, sponsor name and SSN, and attaches a number to the Jane/John Doe name as a unique identification. It is important to update the patient record once the identity of the Jane/John Doe is known.

- Access the John Doe Registration (7) option on the Registration Menu.

PAS System Menu → **EM** → RER → 7

Explain that the prompt - Add new 'John Doe'? YES// - is displayed. You can now add a new Jane Doe to the system.

- Select to add a new John (Jane) Doe: <**Return**>

Explain:

Enter N(O) to reject the addition of the new John Doe, and the system returns to the Registration Menu, or press <Return> to accept the default to add the new John Doe patient.

The John Doe Registration screen is displayed. The header information contains the assigned John Doe patient name and number (i.e., DOE,JOHN93).

- Select Patient Name: **<Return>**

Explain:

The patient name (i.e., DOE,JOHN93) is already appended to this field. The number following Doe,John indicates the number of John/Jane Does in the system.

Press <Return> to accept the default patient name, and exit the field.

- Select FMP: **98** (Civilian Emergency)

Explain that you enter the FMP of 98, indicating a Civilian Emergency, or press <Return> to accept the default FMP and exit the field.

- Select SSN: **<Return>**

Explain:

The system assigns a pseudo social security number beginning with 8 so that the patient can be registered and treated at your facility.

Press <Return> to accept the default SSN, and exit the field.

- Enter Sex: **FEMALE**

Explain that you enter the sex of the patient. This is a required field.

- Enter DOB: **1965**

Explain:

This field can be completed by entering a year or today's date. The entry in this field becomes the date of birth for this patient until corrected information is entered.

If no other information is available, enter T for today's date as the date of birth.

- File the data and exit the option.

Explain that the system exits the John Doe Registration option, and the Registration Menu is redisplayed.

- Return to the Emergency Room Menu.

Explain:

Press <Return> at the prompt to exit the Registration Menu and access the Emergency Room Menu.

The patient is now registered as John Doe. You can now continue to process the patient through the ER using the NER option which was demonstrated in the previous objective.

**Practice 2** - Register a Jane or John Doe patient.

## ■ CHECK-OUT A PATIENT FROM THE EMERGENCY ROOM

**Scenario:** *A patient has been treated in the ER for a hot water burn and is ready to be sent home to rest for three days. You must check this patient out of the ER and give the patient follow-up instructions.*

After patients are treated in the ER, they must be checked out. Patients are checked out individually, or as groups, depending on which option you select.

The Check-Out & Patient Instructions (CER) option is used to check-out an individual patient. The patient must be identified with an ER encounter for the active ER activity processing date.

The CER screen is displayed. This is used to record which provider treated this patient, the patient's release condition, and how the patient was checked out or dispositioned. The continuation screen records patient instructions, ER comments, and allows an update of the patient's chief complaint.

The Outpatient Disposition field must be filled in for the system to record the patient as dispositioned. If the field is left blank, the patient is not considered checked out and will remain in the system as undispositioned.

Each outpatient disposition code has been set in the PAS Outpatient Disposition Code table. Enter a ?? to display a list of codes

Some of the codes are as follows:

- ADMT (Admitted to)
- DISP (Disposition/ER)
- DOA (Dead on Arrival)
- ERD (Emergency Room Death)
- FULL (Full Duty)
- HOME (Home)
- LWBS (Left Without Being Seen)
- MDU (Modified Duty Until)
- Q12 (Quarters for 12 hours)
- Q24 (Quarters for 24 hours)

- Q48 (Quarters for 48 hours)
- Q72 (Quarters for 72 hours)
- REF (Referred to)
- SCHL (Patient returned to school)
- TRAN (Transferred to another MTF)
- WORK (Patient returned to work)
- X-RAY (Send to X-ray).

Each facility can add additional codes to the list. If the patient is admitted to a ward or clinic, then the disposition is ADMT and the admitting ward or clinic is identified. The patient would be admitted by using the appropriate admitting option.

If the patient is referred to a clinic, the disposition code entered is REF, and the ward or clinic referred to is identified. A patient appointment would be entered by using the appropriate booking option.

If the patient is placed on modified duty, then the disposition is MDU and the modified duty ending date is identified.

The CER procedure ends with the option to print an updated Encounter Form SF558.

The Disposition Processing option is used to process patients with ER encounters on a specified date, from a user-specified start time to 2400. Generally, this task is used to process all patients with ER encounters in the date and time range specified. This option can also be used to identify a specific patient in a date/time range. If undispositioned patients exist from another day, the system informs you by displaying a warning message.

The system identifies all patients within the specified date/time range that have not been checked out. You then process each patient, using the CER screens, until all patients have been processed.

The Disposition Processing option, which can be used to disposition more than one patient, is demonstrated later in this lesson.

When the patient is checked out, using either the CER or Disposition Processing options, then the ER encounter status is changed. The ER clinic appointment is assigned a KEPT or Left Without Being Seen (LWOBS) status, depending on how you set the disposition code.

In the first demonstration of this class, the initial status was Walk-in. When an outpatient disposition is entered, the appointment status is changed from Walk-in to Kept, unless the disposition code is LWOBS. All other codes make the appointment status as Kept.

If a disposition code is not entered, the status remains Walk-in, and that patient is not considered checked out.

In this demonstration, the individual patient is being checked out of the ER.

Once check-out for the patient is complete, the system has sufficient information to generate a complete JCAHO Control Register entry. Generation of this register will be discussed later in this lesson.

The CER option is designed to allow you to check-out patients quickly, using few keystrokes. Default information can be set for [Provider], Date/Time of Release NOW//, and Print SF558 YES//.

- Access the Check-Out & Patient Instructions (CER) option on the Emergency Room Menu.

PAS System Menu → **EM** → CER

- Enter ER Patient Name: **S6504** (SCOTT,ALLAN A)
- Confirm the Patient Name: **<Return>**
- Select the ER episode of care: **1** (21 JUN2001@0610)

Explain that the Check-Out & Patient Instructions screen displays.

- Enter Provider: **<Return>**

Explain:

Enter the name of the active provider who attended to this patient, or press **<Return>** to accept the default provider.

This field should not be left blank. It causes the EOD report for this ER to be delinquent, and stat reports will not run.

- Confirm the Provider: **<Return>**

- Enter Date/Time Seen by the Provider: **T@1100**

Explain that this time must be after the ER arrival time and before the ER check-out time. You must follow the date with the time (e.g., 22Jan@1000, T@10PM, etc.). If the year is omitted, the system will use the current year.

- Enter the Date/Time of Release: **T@1200**

Explain that you enter the date/time of the release of this patient, or press <Return> to exit this field.

- Enter Outpatient Disposition: **HOME**

Explain:

A response must be entered in this field for the system to record the patient as dispositioned.

If this field is left blank, the patient is not recorded as dispositioned.

Enter ?? to display a site-specific list of disposition codes.

- Confirm the disposition code selection: **<Return>**

- Enter the Modified Duty Until: **T+3**

Explain:

Enter a date until which the patient will be off-duty due to physical conditions.

Examples of valid ways to enter the date:

- JAN 22 1999
- 22 JAN 99
- 1/22/99
- 012299
- J99022 (Julian)
- T (Today's date)
- T+1 (Tomorrow's date)
- T-1 (Yesterday)
- T-3W (Three weeks ago from today).

If the year is omitted from a date entry, the system uses the current year.

- Enter Referred To: **<Return>**

Explain:

If the patient has been referred to a ward or clinic, enter this information here.

Press <Return> to bypass this field if the patient has not been referred to a ward or clinic.

Enter ?? to display a valid list of wards and clinics.

- Enter Priority: **<Return>**

Explain that you enter one of the following priorities for a patient referral, or press <Return> to bypass this field:

- E (Emergency)
- 7 (72 hours)
- T (Today)
- R (Routine).

- Enter Admitted To: **<Return>**

Explain:

If the patient is being admitted, enter the ward here.

Enter ?? to display a valid list of wards.

- Enter Arrival Category: **EMERGENCY**

Explain:

The system provides information on the patient's arrival category as follows:

- E (Emergency)
- U (Urgent)
- N (Non-urgent).

This information was inserted into the system during patient check-in (NER option).

Enter a new arrival category if appropriate, or press <Return> to accept the default arrival category.

- Enter Release Condition: **IMPROVED**

Explain:

You can enter one of the following release conditions:

- I (Improved)
- U (Unchanged)
- D (Deteriorated).

The next field, Arrival Date/Time, cannot be edited. The data in this field was entered during patient check-in. The cursor bypasses the Arrival Date/Time Field.

- Enter the Method of Transit: **<Return>**

Explain:

The system automatically inserts into this field the method of transit which was originally entered into the system during patient check-in.

Press <Return> to accept the default, or insert another method of transit.

The CER screen is replaced by the CER -- Continuation screen.

- Enter Chief Complaint: **<Return>**

Explain:

The system displays the information that was entered during patient check-in as the chief complaint.

This information can be edited here by typing over it, or press <Return> to accept the default chief complaint.

- Enter Patient Instructions: **DO NOT COVER DAMAGED AREA. LIBERAL APPLICATION OF SILVADINE TO AFFECTED AREA TO PREVENT INFECTION. RETURN IMMEDIATELY AT FIRST SIGN OF INFECTION.**

Explain:

This field is optional.

Enter instructions to the patient which will be printed on the SF558 Encounter Form, or press <Return> to bypass this field.

You may enter patient care instructions of any length in this free-text field.

Patient instructions identify a standard care instruction given to a patient or significant other person describing medication, discharge, dietary or diagnosis-specific activities to be carried out (e.g., stoma care, diabetic meal plan).

- Enter ER Comment: **2ND DEG BURN TO LEFT FOOT**

Explain:

Entries in this field should include any comments (3-40 characters) the ER provider and staff may have regarding this patient during this encounter.

Press <Return> if you do not wish to insert comments.

- File the data.

Explain that the CER -- Continuation screen is replaced by the prompt - Print Encounter Form SF558 Work Sheet: YES//.

- Select to print the SF558: **<Return>**

Explain:

Press <Return> to accept the default to print the SF558.

Enter YES to print the SF558.

The message - Please enter device to print SF558 - is displayed.

- Enter Device [default device]// <**Return**>

Explain:

The SF558 worksheet is printed.

Upon completion of printing, the Emergency Room Menu is redisplayed.

**Practice 3** - Check-out a patient from the Emergency Room.

## ■ UPDATE A PATIENT'S EMERGENCY ROOM ENCOUNTER INFORMATION

**Scenario:** *A patient with a broken foot was seen in the ER. His release condition is noted as improved. You gave him instructions to apply ice to his foot to keep down the swelling. Update the encounter information.*

Patient data often changes. Using the Full ER Encounter (FER) option allows you to use one option to update all of the patient's data. Being familiar with this option can save you steps (and time) in your job.

Once the new patient data has been entered into the system using the NER option, there are several ways you can update or edit the information:

- Enter/edit a problem, procedure, and diagnosis, using the Problem, Procedure, & Diagnosis Enter/Edit (PER) option.
- Update appointment history and encounter data, using the Update, Appt History Encounter Data (UER) option.
- Check-out the patient, providing him/her with instructions (covered in the last demonstration), using the CER option.

You can select the FER option to update all three activities above.

The options you choose depend upon the amount of data you have to edit.

For example, if only the problem, procedure, or diagnosis fields need to be edited, select the PER option. To edit more than one of the areas just stated, select the FER option. In this lesson, you will update specified patient data for an encounter that occurred the previous day using the FER option.

## DISCUSS ANTEDATING ENCOUNTER INFORMATION

There are instances when you may need to update patient information for an ER encounter that occurred before today. To perform this operation, you must first change the system activity date to the date that the ER encounter actually occurred.

### EXAMPLE:

Today is [CURRENT DATE]. On the previous day, patient SANDERS,ALLAN was treated in the ER, then released. Today, you have received supplemental information concerning this encounter that must be entered into the system.

Using the Activity Date and ER Clinic Edit (AER) option on the Emergency Room Menu, you change the activity date to the date of the encounter (T-1) to enter this information.

When finished entering the backdated information, you must remember to change the activity date back to today.

- Access the Activity Date and ER Clinic Edit (AER) option on the Emergency Room Menu.

PAS System Menu → **EM** → AER

- Select Clinic: **ER11**

Explain that you enter the name of the ER clinic for which you wish to enter information.

- Enter ER activity date: **T-1**

Explain:

Press <Return> to accept the default of today as the ER activity date, or enter another date.

When you enter T-1, the message displays:

WARNING: Appointment Date/Time is earlier than Log Date of  
21 Jun 2001.

Continue.

The Emergency Room Menu redisplay.

- Access the Full ER Encounter (FER) option on the Emergency Room Menu.

PAS System Menu → **EM** → FER

- Enter ER Patient Name: **S6501** (SANDERS,ALLAN A)
- Select the patient: **1**

Explain:

The CER screen displays.

This is the same screen in which you entered data to check-out an individual patient.

**Note:** If the date of patient arrival at the ER is not the same as the entered Activity Date, the message - No ER Encounter Found for [patient] on [activity date] in Emergency Room - is displayed. To backdate information, you must change the Activity Date using the AER option, then restart this option.

You can now edit existing data or enter new data.

This demonstration covers entering check-out data, viewing information related to the encounter appointment, and entering data related to problem, procedure, and diagnosis.

- Enter Provider: **<Return>**

Explain:

If the name of the provider who attended this patient has not been entered, enter the name of the provider.

A default provider can be defined in the ER Profile.

Press <Return> to accept the default provider, or if no default provider is listed and the provider is unknown.

- Confirm the Provider: **<Return>**
- Enter Date/Time seen by the Provider: **T-1@1200**

Explain:

This time must be after the ER arrival time and before the ER check-out time.

The Date/Time default can be set to NOW in the ER Profile.

- Enter the Date/Time of Release: **T-1@1500**

Explain that you enter the date/time of the release of this patient, or press <Return> to exit this field.

- Enter Outpatient Disposition: **HOME**

Explain:

A response must be entered in this field for the system to record the patient as dispositioned.

If this field is left blank, the patient is not recorded as dispositioned.

Enter ?? to display a site-specific list of disposition codes.

- Confirm the disposition code selection: **<Return>**
- Enter the Modified Duty Until: **T+3**

Explain that you enter a date until which the patient will be off-duty due to physical conditions, or press <Return> to bypass this field.

- Enter Referred To: **<Return>**

Explain:

If the patient has been referred to a ward or clinic, enter this information here.

Press <Return> to bypass this field if the patient has not been referred to a ward or clinic.

- Enter Priority: **<Return>**

Explain that you enter a priority, or press <Return> to bypass this field.

- Enter Admitted To: **<Return>**

Explain:

If the patient is being admitted, enter the ward here.

If the patient is not being admitted, press <Return> to bypass this field.

- Enter Arrival Category: **EMERGENCY**

Explain:

This information was inserted into the system during patient check-in (NER option). Enter a new arrival category if appropriate.

- Enter Release Condition: **IMPROVED**

Explain:

You can enter one of the following release conditions:

- I (Improved)
- U (Unchanged)
- D (Deteriorated).

The next field, Arrival Date/Time, cannot be edited. The data in this field was entered during patient check-in. The cursor bypasses the Arrival Date/Time Field.

- Enter the Method of Transit: **<Return>**

Explain:

The system automatically inserts into this field the method of transit which was originally entered into the system during patient check-in.

Press <Return> to accept the default, or insert another method of transit.

The CER screen is replaced by the CER -- Continuation screen.

- Enter Chief Complaint: **<Return>**

Explain:

The system displays the information that was entered during patient check-in as the chief complaint.

This information can be edited here by typing over it, or press <Return> to accept the default chief complaint.

- Enter Patient Instructions: **STAY OFF OF FOOT. KEEP FOOT ELEVATED WHEN POSSIBLE. APPLY ICE.**

Explain:

Enter instructions to the patient which will be printed on the SF558 Encounter Form, or press <Return> to bypass this field.

You may enter patient care instructions of any length in this free-text field.

- Enter ER Comment: **<Return>**

Explain:

Entries into this field should include any comments the ER provider and staff may have regarding this patient during this encounter.

Press <Return> if you do not wish to insert comments.

- File the data.

Explain that the CER -- Continuation screen is replaced by the prompt - Print Encounter Form SF558 Work Sheet: YES//.

- Select not to print the SF558: **N**

Explain:

The default YES or NO is controlled by the entry in the associated field in the ER Profile.

Enter N(O) not to print the SF558.

The UER screen is displayed.

You can now update appointment history and encounter data.

The header information that was displayed in the CER screen is also the same for this screen.

- Enter Appointment Type: **<Return>**

Explain:

This field is defaulted to the ER.

Edit the appointment type, or press <Return> to accept the default.

- Enter Appointment Status: **<Return>**

Explain:

If the patient has been dispositioned, the appointment status of Kept is automatically inserted by the system. If the patient left without being seen, then the appointment status is LWOBS.

Edit the appointment status, or press <Return> to accept the default.

- Enter MEPRS Code: **<Return>**

Explain:

The MEPRS code default for this ER is displayed in this field.

Edit the appointment MEPRS code, or press <Return> to accept the default.

The next field is the Third Party Payer field, which is defaulted to NO, and cannot be edited. The data in the Third Party Payer field was entered during patient check-in. The cursor bypasses the Third Party Payer field.

- Enter Secondary Provider: **<Return>**

Explain:

This field allows you to enter a secondary provider if one was used during this encounter.

Enter a double question mark (??) to display a list of valid active providers at your facility from which you can make a selection.

If a secondary provider was not employed for this encounter, press <Return> to bypass this field.

- Select Trackable Entity: **PAIR OF CRUTCHES**

Explain:

You may enter a trackable entity if you wish. A trackable entity is any equipment loaned to the patient from the ER (i.e., crutches, cane, etc.).

Enter a trackable entity, or press <Return> to exit the field without making an entry.

- Confirm the trackable entity entry: **<Return>**

Explain:

You can enter another trackable entity, or press **<Return>** to exit the field.

The UER screen is then replaced by the UER -- Continuation screen.

The UER -- Continuation screen contains the same header information as the previous screen. The UER -- Continuation screen (body) contains the following informational fields:

- Next of Kin
- NOK-Phone
- Command Security
- Military Flying Status.

- Enter Next of Kin: **<Return>**

Explain:

This field may already be filled in with the Next of Kin (NOK) from the previous registration process.

If not, enter the NOK, if known, or press **<Return>** to exit the field without making an entry.

- Enter NOK-Phone: **<Return>**

Explain:

This field may already be filled in with the NOK telephone number from the previous registration process.

If not, enter the NOK telephone number, if known, or press **<Return>** to exit the field without making an entry.

- Enter Command Security: **<Return>**

Explain:

This field is related to the PATCAT field entry made during registration.

If the patient category entered for this patient during registration indicates that the patient is active duty military, then the system allows you to enter this field to enter information.

If the patient category indicates that this patient is not active duty military, the system will bypass this field.

As was the case during registration, it is important to complete this field if the active duty military patient is designated as a member of one of three designated security programs.

If the active duty military patient is not a member of one of the designated security programs, press **<Return>** to exit this field without an entry.

- Enter Military Flying Status: **<Return>**

Explain:

This field is related to the PATCAT field entry made during registration.

If the patient category entered for this patient during registration indicates that the patient is active duty military, then the system allows you to enter this field to enter information.

If the patient category indicates that this patient is not active duty military, the system will bypass this field.

This field indicates whether or not the patient is in a Military Flying Status. Enter YES if the patient is in a Military Flying Status, or enter NO if the patient is not.

The UER screen redisplay.

- File the data.

Explain:

The UER screen is replaced by the PER screen. You can now enter PER data.

The cursor is located in the Select Diagnosis field.

- Select Diagnosis: **824.9**

Explain:

You may enter a new diagnosis for this patient in this field if you wish.

Enter a valid International Classification of Diseases (ICD) code as a diagnosis for this patient (i.e., 824.9 is the ICD code for a broken ankle).

Diagnosis is the ICD representation of this patient's current primary, secondary, or any related diagnosis(es).

Enter ?? to display a valid list of ICD diagnosis codes.

Press <Return> to bypass this field without making an entry.

If a diagnosis is entered, the PER -- Continuation screen is displayed. This screen contains the Description and Job Related fields.

- Enter at Diagnosis: <Return>
- Enter at Description: <Return>

Explain that this field provides a free-text area (2-225 characters) in which supplemental information for the diagnosis can be entered.

- Enter at Job Related: **NO**

Explain:

Enter YES or NO to indicate if the diagnosis is job related.

Job related diagnosis indicator denotes whether a patient's diagnosis is job related, as identified by the provider.

The PER screen redisplay.

Press <Return> to exit the Select Diagnosis field.

- Select Diagnosis (Free Text): **BROKEN ANKLE**

Explain:

Diagnosis (free text) is the full textual description (3-60 characters) of this patient's current primary, secondary, or any related diagnosis(es).

If no diagnosis (free text) is to be entered, press <Return> to exit this field without making an entry.

After diagnosis (free text) entry, the prompt - Are you adding [diagnosis] as a new DIAGNOSIS (FREE TEXT) (the [nth] for this encounter)? - is displayed.

- Confirm Diagnosis (Free Text) Selection: **<Return>**

Explain:

The cursor moves to the bottom of the diagnosis (free text) list.

You may enter another diagnosis (free text) or press <Return> to exit this field.

- Exit the Diagnosis (Free Text) Field: **<Return>**

Explain that the PER screen is replaced by the PER -- Continuation screen.

- Enter Chief Complaint: **<Return>**

Explain:

The system displays the information that was entered during patient check-in as the chief complaint.

This information can be edited here by typing over it, or press <Return> to accept the default chief complaint.

- Enter Patient Instructions: **<Return>**

Explain:

Previously entered data displays.

This information can be edited, or press <Return> until the cursor is on the blank line at the bottom of the text.

- Exit the Patient Instructions Field: **<Return>**

- Select Problem Code: **<Return>**

Explain:

You may enter a new problem code from the database of ICD codes maintained by your facility.

Enter a double question mark (??) to display a list of valid ICD codes.

If you do not wish to make an entry, press <Return> to exit this field.

- Select Procedure: **<Return>**

Explain:

You may enter a code for a procedure that was performed on or for this patient.

The procedure code identifies a clinical care service, test, or procedure performed within or outside the facility.

Enter ?? to display a valid list of Procedure codes (example: 01.15 is a skull biopsy).

If you do not wish to make an entry, press <Return> to exit this field.

- Select Procedure (Free Text): **CAST**

Explain:

Procedure (free text) is the full textual description (3-60 characters) of the procedure used on or for the treatment of this patient.

If no procedure (free text) is to be entered, press <Return> to exit this field without making an entry.

After procedure (free text) entry, the prompt - Are you adding [procedure] as a new PROCEDURE (FREE TEXT) (the [nth] for this encounter)? - is displayed.

- Confirm Procedure (Free Text) Selection: **<Return>**

Explain:

The cursor moves to the bottom of the diagnosis (free text) list.

You may enter another procedure (free text) or press <Return> to exit this field.

- File the data.

Explain that the system returns to the Emergency Room Menu.

**Practice 4** - Update a patient's Emergency Room encounter information.

## ■ VIEW PAST AND FUTURE APPOINTMENTS, AND WAIT LIST REQUESTS FOR A SPECIFIED PATIENT AND FAMILY MEMBER

**Scenario:** *A cardiac patient has arrived at the ER via ambulance and needs immediate attention. You discover that this patient has been seen previously at this facility and you need to see this patient's appointment history.*

Sometimes, patients will not remember the name of their provider, or will request a list of future appointments. The View Patient Appointment History (VER) option is a quick method of looking up a patient's past and future (pending) appointments and Wait List requests. After viewing the appointment history for the patient, you can quickly check appointment histories for other family members.

- Access the Activity Date and ER Clinic Edit (AER) option on the Emergency Room Menu.

PAS System Menu → **EM** → AER

- Select Clinic: **ER11**

Explain:

In the last demonstration, you changed the activity date in order to backdate information. Now that this action is complete, you must change the activity date back to today.

Enter the name of the ER clinic for which you wish to change the activity date.

- Enter ER Activity Date: **<Return>**

Explain:

Press <Return> to accept the default of today as the ER Activity Date, or enter another date.

The Emergency Room Menu redisplay.

- Access the View Patient Appointment History (VER) option on the Emergency Room Menu.

PAS System Menu → **EM** → VER

- Refer to Quick Reference Guide: Display Patient Appointments.
- Enter Patient Name: **S6501** (SANDERS,ALLAN A)

- Select the patient: **1** (SANDERS,ALLAN A)

Explain that the action bar - Select (F)uture, (P)ast, (W)ait List, (S)pecific Date, (Q)uit: F// - displays.

- Select Appointments by Past Appointments option: **P**

Explain that when you select the Past Appointments action, the system displays/prints all appointment history from today into the past.

- Enter at Device: **<Return>**

Explain:

Press <Return> to display data on your screen, or enter a device identifier to print the data.

Enter a double question mark (??) to display a list of printers to use at your facility.

- Enter at Right Margin: **<Return>**

Explain:

The Display Patient Appointments screen displays for this patient. The top section lists the past or future appointments for this patient in chronological order by clinic/division, provider, date/time, type, and status. Past appointments display only back to the date in the past that you entered. However, if there is no history of appointments, the message - No record of appointments - displays.

It is important to note the division in which each clinic resides when referring to an appointment or a Wait List request.

If you selected to display Wait List requests, the lower section lists the Wait List requests by clinic/division, type, priority, date in, target date, and provider. If there are no Wait Lists requests for this patient, the message - No Wait List requests - displays.

The prompt - Press <Return> to continue - displays.

- Press **<Return>** (to continue).
- Select to display or print appointment history of another family member: **Y**

- Select family member: **1** (SANDERS,ANDY)

Explain:

A selection list of family members displays.

The FMP 01 designates the oldest child of the sponsor.

Enter the selection list number corresponding to the family member whose appointment information you wish to display.

- Select the Past Appointments action: **P**
- Enter at Device: **<Return>**
- Enter at Right Margin: **<Return>**

Explain:

The Display Patient Appointments screen is displayed again, but this time it contains the Appointment/Wait List data for the selected family member.

Clinics are listed with divisions.

The prompt - Press **<Return>** to continue - is displayed.

- Press **<Return>** (to continue).
- Select not to display or print appointment history of another family member: **<Return>** (to exit the option).

Explain:

Press **<Return>** to accept the default not to display/print appointment history for other family members.

This action exits this option automatically and returns to the Emergency Room Menu.

**Practice 5** - View past and future appointments, and Wait List requests for a specified patient and family member.

## ■ REPRINT THE SF558

**Scenario:** *The printer jammed when you were printing the encounter form so you must print another one.*

The Encounter Form SF558 worksheet is an 80-column worksheet that contains information from processing a new ER encounter. All of the information entered at that time is recorded on the SF558. The SF558, with the provider's handwritten comments, is the legal encounter form. It must be filed in the patient's record.

For this demonstration, you will use the SER option on the Emergency Room Menu to print the Encounter Form for a specific patient on a specified device.

- Access the SF558 Print (SER) option on the Emergency Room Menu.

PAS System Menu → **EM** → SER

Explain that the header - SF558 Print [ER Activity Date] - displays.

- Select ER Patient Name: **S6504** (SCOTT,ALLAN A)
- Confirm selection: **<Return>**

Explain:

The system confirms the response and displays the date and time of the patient's ER encounter.

The system only displays encounters from the past seven days.

If the patient has had more than one ER encounter, you must select which encounter to print.

- Select the encounter: **1**

Explain that the Device prompt displays.

- Enter at Device: **HOME**, then **<Hold Screen>**

Explain:

The SF558 worksheet displays on your screen. As soon as the SF558 worksheet displays and begins to scroll, press **<Hold Screen>**.

- Release the SF558 Worksheet: **<Hold Screen>**

Explain that after you view the SF558 worksheet, press <Hold Screen> again. The system automatically returns to the Emergency Room Menu.

**Practice 6** - Reprint the SF558.

## ■ GENERATE A PARTIAL JCAHO CONTROL REGISTER

**Scenario:** *Your supervisor has requested that you generate today's JCAHO Control Register for the ER.*

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Register Log lists patient encounters in ERs at the facility for a previous date or the current date. A partial ER log can be generated that shows appointments up to the designated time before day's end. The log is sorted by hospital location: clinic, division, or entire facility, then appointment time.

PAS can support a facility with more than one ER. To generate the log, identify which location should be reported in the log. Identify which location by selecting a range of locations from the action bar - Select (C)linic, (D)ivision, or (A)ll for Entire Facility - when appropriately displayed. If you select (C)linic, you can choose from an alphabetized list of Emergency Rooms in the database.

Identify which location(s) to record by selecting the clinic and then entering a double question mark (??) to display the alphabetized list of Emergency Room locations in the database. Select those you want.

Next, identify the date and time of the log. The date indicates appointment dates, and includes the ending or last appointment time for listed appointments. An appointment date is required. If no appointment time is listed, the current time is used.

The JCAHO Control Register Log is a 132-column report and generally requires an appropriate printer identification. However, when the device prompt displays, enter PAS WIDEFORM to print the report on an 80-column slave printer attached to your terminal. The report prints in a compressed format.

## DISCUSS THE REGISTRATION MENU AND THE MANAGEMENT REPORTS MENU

The Registration Menu and the Management Reports Menu on the Emergency Room Menu have forms and reports used in the ER.

The Registration Menu allows you to generate the following items:

- Registration forms
- Embossed cards
- Requests for medical records.

The registration form contains all of the patient's registration information. The embossed card is the patient's identification card. The Request a Record option allows you to pull patient medical records immediately instead of waiting for the usual, or scheduled, pull time.

The process of generating the registration form is similar to that for generating the SF558 Encounter Form, and is a straightforward procedure. Enter the clinic (if applicable), patient name, and print parameters.

The Management Reports Menu (MER) contains three options:

- Clinic Workload Report
- End-of-Day Processing/Editing
- Trackable Entity Report.

## **DISCUSS THE CLINIC WORKLOAD REPORT**

The Clinic Workload Report totals encounters for a specific clinic and for a specific date range in the following order:

- The first section of the report is the subtotal and total by appointment types.
- The second section is the subtotal and total by provider for each appointment type.
- The third section is the statistics by patient code and category description.
- The fourth section is the total for the clinic by MEPRS code.

## **DISCUSS THE END-OF-DAY PROCESSING/EDIT OPTION**

The End-of-Day Processing/Edit option allows you to edit, modify, or update appointment history data including the status of daily encounters for each ER clinic and ER provider.

This option provides the means by which the computer database is updated to reflect what has really happened in the ER clinic and which data is reported in numerous statistical reports.

This option allows you to update or correct patient appointment history data and review the status of daily encounters.

This option enables you to specify whether an appointment status is Walk-In, Telephone-Consult, Sick-Call, Occasion of Service (OCC-SVC), Admin, or Left Without Being Seen (LWOBS).

This option allows you to update the appointment status of any patient who was checked in manually.

Updates must be completed within seven days of the appointment. After seven days, only supervisory personnel with the required security key will be able to perform end-of-day processing.

### **Discuss the Trackable Entity Report**

The Trackable Entity Report displays all trackable entity data by clinic or division.

This report displays the date, ER log #, patient name and telephone number, FMP/SSN, and work telephone number for every trackable entity loaned from a clinic.

The following demonstration will show you how to generate a partial register using the JCAHO Control Register Print option.

- Access the JCAHO Control Register Print (JER) option on the Emergency Room Menu.

PAS System Menu → **EM** → JER

- Refer to Quick Reference Guide: End-of-Day Processing.

Explain:

This demonstration procedure covers how to generate a partial JCAHO Control Register for one specific ER location in a facility where there are several ERs.

The selection bar - Select (C)linic, (D)ivision, or (Q)uit - is displayed. You can now select hospital location parameters.

- Select the Clinic option: **C**

Explain the options:

- C - Selects a JCAHO Control Register for a clinic.
- D - Selects a JCAHO Control Register for a division.
- Q - Quits the selection bar and returns the system to the Emergency Room Menu.

The Select Clinic prompt is displayed.

- Enter ER Clinic: **ER11**

Explain that the prompt - ER Log Start Date/Time (Time must be before NOW): [today's date/time]// - is displayed.

- Select ER Log Start Date/Time: **<Return>**

Explain:

Enter any date through today's date and any time before now, or press <Return> to accept the default of today at 0001.

The prompt - ER Log Stop Date/Time: [today's date/time now]// - is displayed.

- Select ER Log Stop Date/Time: **<Return>**

Explain:

Enter a specific date and time, or press <Return> to accept the default of NOW.

**Note:** Since you are looking for a listing of today's appointments up to the current time, you do not need to enter a specific time.

When you need to specify the time, you must separate the date and the time entries with a "@" sign (i.e., to list yesterday's patients that arrived before noon, you enter T-1@1200).

The message - This is a 132 column report! - is displayed. The Select Device prompt is also displayed.

- Select Device: **HOME**

Explain:

At the device prompt, you can enter PAS WIDEFORM to print in compressed format to the slave printer, or HOME to print to the screen.

After the device is entered, the report prints.

The system automatically returns to the Emergency Room Menu.

**Practice 7** - Generate a partial JCAHO Control Register Log.

## ■ DISPOSITION ALL PATIENTS FROM THE EMERGENCY ROOM

**Scenario:** *ER personnel have checked in several patients in the last several hours. No one has had an opportunity to disposition any of the patients until now. You must now disposition the patients.*

The steps for dispositioning all patients at once are the same as the steps you use to check-out patients individually (this was discussed during the third demonstration of this class), except as follows:

The system automatically calls up each patient for you, instead of you having to enter each patient's name one at a time. The system keys off an entry in the Outpatient Disposition field. That is, if the Outpatient Disposition field is not filled in, the system locates and presents the patient data display for disposition at this time. If the Outpatient Disposition field is filled in, the system bypasses that patient.

**Note:** Workload reporting for the ER is counted based on information in the Appointment Status field, not the Outpatient Disposition field.

There is no SF558 Encounter Form to generate.

**Note:** The Emergency Room Menu is displayed.

- Access the Disposition Processing (DER) option on the Emergency Room Menu.

PAS System Menu → **EM** → DER

Explain:

Disposition of all patients is generally something that occurs when patient workload and/or hospital staffing does not permit check-out as the patient leaves the ER.

If all patients have been dispositioned for a day and someone tries to disposition again, the message - No ER encounters require disposition for [date/time] - is displayed.

The prompt - Start Date/Time to Begin Processing: TODAY@0001// - is displayed.

- Select Start Date/Time to Begin Processing: **<Return>**

Explain:

Enter a different date/time, or press <Return> to accept the default of today at time 0001.

If you accept the default, the system retrieves and displays records for all ER patients since 0001 that day without an entry in the Outpatient Disposition field. The purpose for this option is to disposition all patients for a specific time frame. For example, if you wanted to disposition all patients who were checked in during the last four hours, enter T@ and the start time.

If you need to disposition all patients from 2000 to 2400 the day before, enter yesterday's date and 2000.

If there are patients who have not been dispositioned prior to today's date, the message - **\*\*WARNING\*\*** There are undispositioned patients for [date] - is displayed.

The prompt - Select Patient: ALL// - displays.

- Enter ER Patient Name: **<Return>**

Explain:

Press <Return> to accept the ALL ER patients default.

No SF558 worksheets are generated when using this option.

The CER screen for the patient, SULLIVAN,ALLAN A, is presented.

- Enter Provider: **<Return>** (QUURN)

Explain:

Enter the name of the active provider who attended to this patient, if different than the one displayed, or if the field is blank.

Press <Return> to accept the default provider, QUURN, or press <Return> if no default provider is listed and the provider is unknown.

- Confirm the Provider: **<Return>**

- Enter Date/Time Seen by the Provider: **T@1100**

Explain that you enter the date/time that this patient was seen by the provider.

- Enter the Date/Time of Release: **T@1130**

Explain:

Enter the date/time of the release of this patient, or press <Return> to exit this field without an entry.

This time must be after the ER arrival time and before the ER release time. You must follow the date with the time (e.g., Jan 22@10, T@10PM, etc.). If the year is omitted, the system uses the current year.

- Enter Outpatient Disposition: **HOME**

Explain:

A response must be entered in this field for the system to record the patient as dispositioned. If this field is left blank, the patient is not recorded as dispositioned.

Enter a double question mark (??) to display a site-specific list of disposition codes.

- Confirm the disposition code selection: **<Return>**

- Enter the Modified Duty Until: **<Return>**

Explain that you enter a date until which the patient will be off-duty due to the physical condition, or press <Return> to continue.

- Enter Referred To: **<Return>**

Explain:

If the patient has been referred to a ward or clinic, enter this information here. Press <Return> to bypass this field if the patient has not been referred to a ward or clinic.

Enter a double question mark (??) to display a valid list of wards and clinics for your site.

- Enter Priority: **ROUTINE**

Explain:

If the patient is referred to another location, this field is used to indicate how soon this must happen.

Enter one of the following priorities for patient referral:

- E (Emergency)
- 7 (72 hours)
- T (Today)
- R (Routine).

- Enter Admitted To: **<Return>**

Explain:

If the patient is being admitted, enter the ward here.

Enter ?? to display a valid list of wards.

- Enter Arrival Category: **<Return>**

Explain:

The system provides information on the patient's arrival category as follows:

- E (Emergency)
- U (Urgent)
- N (Non-urgent).

This information was inserted into the system during patient check-in (NER option).

- Enter Release Condition: **IMPROVED**

Explain:

You can enter one of the following release conditions:

- I (Improved)
- U (Unchanged)
- D (Deteriorated).

The next field, Arrival Date/Time, cannot be edited. The data in this field was entered during patient check-in. The cursor bypasses the Arrival Date/Time field.

- Enter the Method of Transit: **<Return>**

Explain:

The system automatically inserts the method of transit into this field, which was originally entered into the system during patient check-in.

Press <Return> to accept the default, or insert another method of transit.

The CER -- Continuation screen replaces the CER screen.

- Enter Chief Complaint: **<Return>**

Explain:

The system displays the information that was entered during patient check-in as the chief complaint.

This information can be edited here by typing over it, or press <Return> to accept the default chief complaint.

- Enter Patient Instructions: **<Return>**

Explain:

This field is optional.

Enter instructions to the patient, or press <Return> to bypass this field.

You may enter patient care instructions of any length in this free-text field.

Patient instructions identify a standard care instruction given to a patient or significant other person describing medication, discharge, dietary or diagnosis-specific activities to be carried out (e.g., stoma care, diabetic meal plan).

- Enter ER Comment: **<Return>**

Explain:

Entries in this field should include any comments (3-40 characters) the ER provider and staff may have regarding this patient during this encounter.

Press <Return> if you do not wish to insert comments.

- File the data.

Explain that the CER -- Continuation screen is replaced by the prompt - Press <Return> to continue, type <^> to escape.

- Continue to disposition patients: **<Return>**

Explain:

If there is another patient for dispositioning, the check-out process is continued. If all patients have been dispositioned, pressing <Return> to continue will return you to the main menu.

The CER screen for the next patient (SULLIVAN,BARBARA B) displays. You can now complete the CER screens for the second patient.

- Enter Provider: **<Return>** (QUURN)

Explain that you press <Return> to accept the default provider, QUURN.

- Confirm the Provider: **<Return>**
- Enter Date/Time Seen by the Provider: **T@1130**
- Enter the Date/Time of Release: **T@1300**
- Enter Outpatient Disposition: **HOME**
- Confirm the disposition code selection: **<Return>**
- Enter the Modified Duty Until: **<Return>**
- Enter Referred To: **<Return>**

- Enter Priority: **ROUTINE**
- Enter Admitted To: **<Return>**
- Enter Arrival Category: **<Return>**
- Enter Release Condition: **IMPROVED**
- Enter the Method of Transit: **<Return>**

Explain that the First CER screen is replaced by the CER -- Continuation screen.

- Enter Chief Complaint: **<Return>**
- Enter Patient Instructions: **<Return>**
- Enter ER Comment: **<Return>**
- File the data.

Explain that the CER -- Continuation screen is replaced by the prompt - Press **<Return>** to continue, type **<^>** to escape.

- Exit the option: **<^>**

Explain that you enter **<Return>** to display the CER screen for the next patient, or press **<^>** to exit the option and return to the Emergency Room Menu.

- Return to the PAS System Menu.

**Practice 8** - Disposition specified patients from the Emergency Room using the Disposition Processing option.

## ■ DISCUSS EMERGENCY ROOM PARAMETERS

**Scenario:** *You have been directed to add a new method of transit to your ER clinic's list of ER parameters. You need to update the file to reflect the new method of transit.*

- Access the File/Table Maintenance Menu (FILE) option on the Scheduling Supervisor Menu.

### **PAS System Menu → S → FILE**

Not all users can access the File/Table Maintenance Menu. Profile parameters control which users are allowed to access and use this menu. The parameters are called security keys.

## **DISCUSS SECURITY KEYS**

Security keys and processing locks can be compared to keys to locked office doors. Some staff members may have a key to unlock the door to the office suite. Those with more authority will have keys to the suite and their own private office. The office manager distributes keys according to use, just as the system manager assigns security keys to CHCS users.

Security keys are created by the system manager at your facility. PAS security locks restrict access to certain PAS functions including the File/Table Maintenance Menu. Each subsystem usually has its own set of security keys which are assigned to certain users.

As you learned in the CHCS Orientation class, security locks/keys are also used to restrict the use of certain menus and options. Only those users who hold the appropriate keys can access the menus and options.

After logging on to the system, if the File/Table Maintenance Menu is not listed on the Scheduling Supervisor Menu on your terminal, then you do not have the security key to access it.

Security keys are not defined in the PAS profiles; these locks are built into the system.

## **DISCUSS THE FILE/TABLE MAINTENANCE MENU**

The options in the File/Table Maintenance Menu allow you to create new clinics/ERs, maintain PAS tables, and define the PAS mailers used for Wait List processing.

Each table contains codes and the meaning of the codes. The table entries are displayed when you enter ?? at the related field. The PAS-specific tables used in ER processing are:

- Method of Transit (FILE → MFIL)
- Outpatient Disposition (FILE → OFIL)
- Trackable Entity (FILE → TFIL).

Through these table options, you can enter outpatient disposition and trackable entities parameter types, or edit current ones entered by your facility.

The codes listed in these tables apply to the entire facility. The Method of Transit table identifies codes for all possible methods by which a patient could be transported to an ER (i.e., AMB = ambulance).

The Outpatient Disposition table identifies codes that describe the method of patient disposition from the ER (i.e., HOME = sent home). Some values are pre-loaded, and additional entries may be made by site personnel.

The Trackable Entities table contains codes that describe all trackable reusable materials and equipment loaned to patients (i.e., crutches). All values must be added by site personnel.

PAS software allows you to maintain files and tables without relying on the database manager. However, data delivered with CHCS software cannot be edited, deleted, or deactivated. New codes can be added to the PAS tables and edited by site personnel. The maintenance procedure is the same for each table. The number of fields that can be edited depends on the table.

The Patient Appointment and Scheduling Reference Manual lists menus and menu definitions for PAS-maintainable tables.

**Practice** - There is no practice for this objective.

### **III. BRIEF PRESENTATION**

#### **INTRODUCE THE PATIENT APPOINTMENT AND SCHEDULING (PAS) SYSTEM MENU**

- Log on to CHCS and access the PAS System Menu.

The PAS System Menu is the primary menu for PAS-related functions using CHCS.

#### **INTRODUCE THE PATIENT APPOINTMENT AND SCHEDULING REFERENCE MANUAL**

A reference manual is available at each terminal for use in the classroom.

- The manual is also available at your workcenter.
- All menu definitions are contained in the manual.
- Refer to the Patient Appointment and Scheduling Reference Manual for applicable menu diagrams and definitions and procedural flowcharts.
- Enter ??? (to access the menu option descriptions online).

#### **INTRODUCE THE PAS EMERGENCY ROOM MENU**

- Access the Emergency Room (EM) Menu on the PAS System Menu.

##### **PAS System Menu → EM**

- Describe the PAS System Menu options.

## ■ CHECK-IN A PATIENT TO THE EMERGENCY ROOM AND PRINT THE SF558

**Scenario:** *A visitor collapses in the lobby of the hospital and is brought to the ER. She is not registered at this facility, so you must register her using the Mini Registration option, then check-in the patient.*

The Emergency Room Menu option is located on the PAS System Menu. Selecting this option presents you with a brief series of prompts to the Emergency Room Menu. From this one menu, you can select all the options required in Emergency Room (ER) processing. During the Emergency Room Processing class, you will be working from this menu.

Your facility may have one or more ERs. An ER Profile is created for each ER at your facility, and is accessible through the Emergency Room Profiles Menu (EER) option. In the ER profile, the Is This An Emergency Room? field indicator is set to YES. To the Composite Health Care System (CHCS), this identifies your clinic location as an ER. PAS considers patient encounters in an ER as Walk-In appointments for that ER.

If you first logged on to the system and selected an option from the Emergency Room Menu, the system prompts you for an ER clinic and activity date. The clinic and activity date entries establish an active ER clinic and an active ER activity date used for the ER processes that follow. During your use of ER Processing options, you are not prompted for an ER clinic or activity date again unless you return to the PAS System Menu and select/reselect the Emergency Room Menu.

This lesson assumes that you are working in only one division. If you are working in one division, and are then assigned to work in another, you must obtain access to work in both divisions.

The first two objectives/demonstrations of this lesson explain how to check-in ER patients in the CHCS. The patients that are checked into an ER may be:

- Registered at the facility
- Unregistered at the facility
- Jane/John Doe patients (unable to communicate registration information).

PAS provides options on the Emergency Room Menu that allow you to process patients in any of these situations.

The New ER Patient Enter (NER) option on the Emergency Room Menu is used to check-in ER patients. This option establishes an appointment record for the patient in the active ER clinic on the active ER activity date. The appointment status is automatically set to Walk-In.

If the patient is already registered at your facility, you can use the NER option to update that existing registration, then check the patient into the ER. If the patient is not registered at your facility, the NER option is used to register and check-in the patient to the ER.

If the patient is a Jane or John Doe, the NER option is used to create a patient record for a DOE,JANE or DOE,JOHN; register this unknown patient; and check-in the patient to the ER.

Options on the Registration Menu can be used before or after using the NER option to edit patient information, register a new patient, or assign a tentative name for a Jane/John Doe to enter information about the ER encounter.

- Access the New ER Patient Enter (NER) option on the Emergency Room Menu.

PAS System Menu → **EM** → NER

- Refer to Quick Reference Guide: Patient Lookup.
- Select Clinic: **ER11**
- Enter ER activity date: <**Return**>

## **REGISTER THE PATIENT INTO YOUR FACILITY**

Register the unregistered patient into CHCS before checking in the patient to the ER.

You also have the option of entering a Jane or John Doe Registration. Enter an ampersand (&) <Shift> <7>. The procedure to register and check-in a Jane or John Doe is covered in the next demonstration.

After entering a registered patient's name, the system displays the patient's family member prefix (FMP), Social Security number (SSN), birthdate, sex, and command security code (if applicable). The system then requires patient name verification: OK? YES//.

For the registered patient, the Demographics Display screen is displayed. The patient's registration data can then be edited, if necessary.

If the registered patient has been inadvertently identified as a duplicate patient (i.e., the patient has been registered twice under different names), the system issues a message stating which name to use. When you confirm the patient name, you will be confirming the patient that the system has selected.

If any family member (patients with the same sponsor SSN) has had changes in demographic data, a screen with the next of kin's name and demographic fields to update is displayed. Below the next of kin information is the prompt - Do you want to move information to [next of kin's name]? YES//. You can press <Return> to accept the default, or, if you do not wish to have the information transferred to the next of kin, enter NO.

If there is more than one family member for this sponsor, you will be prompted to update the registration data for each family member. However, in this scenario, the patient to be checked in to your ER is not registered into your facility. Therefore, before this patient, who is her own sponsor, can be checked in, she must first be registered into your facility.

Start the registration process by entering the unregistered patient's identifier at the prompt.

Since this patient is not registered at this facility, the system accesses Mini Registration and allows registration of the patient at this time.

## **REVIEW PROPER PATIENT LOOKUP PROCEDURES**

It is critical to identify patients in CHCS correctly.

Small differences in the entry of a patient name can create a duplicate patient entry.

Since duplicate records in the system can significantly impact patient safety, reduce system response time, and are difficult to correct, the following three-step method of patient lookup is strongly recommended prior to registering a new patient:

First Step: Enter the first letter of the patient's last name and the last four digits of the sponsor's SSN.

Second Step: Enter the sponsor's full SSN.

Third Step: Enter the patient's last name.

These three steps will be followed for this demonstration.

- Enter Patient Name: **S6101** (SHANKS,ALICIA A)
- Enter Patient Name: **611616101** (SHANKS,ALICIA A)
- Enter Patient Name: **SHANKS** (SHANKS,ALICIA A)
- Enter Patient Name: **SHANKS,ALICIA A**
- Confirm that you are adding SHANKS, ALICIA A as a new Patient: **Y**
- Enter Sponsor Name: **spacebar**, then **<Return>**
- Enter Sponsor FMP: **20**

## **DISCUSS THE HELP WINDOWS**

A popup window is displayed on the screen under the following conditions: a double question mark (??) was entered at the prompt, invalid data is entered, or verification that the information being added to the system is needed.

### **Discuss Displaying Help by Entering ??**

When ?? is entered at a prompt, a popup window displays on the screen containing information relevant to responding to the prompt.

Some examples of help text are as follows:

THE ANSWER MUST BE 3-30 CHARACTERS IN LENGTH

This field defines which Location Group for an IV Room will contain the IV orders that are forwarded to it from another IV Room.

This free text field identifies the IV location Group Name.

When more help text is available than the information presented in the help window, the (M)ore help action is displayed in the bottom portion of the help window.

### **Discuss Displaying the List of Valid Entries**

When the prompt can be responded to from a list of valid entries, the (L)ist of values action is displayed in the bottom portion of the help window.

If a plus sign (+) is displayed at the top or bottom of the list, use the up-arrow and down-arrow keys to display additional items on the list.

When the item to be selected in response to the prompt is displayed, use the up-arrow and down-arrow keys to position the cursor at the desired item and press <Select>.

### **Discuss the Keyboard Help Feature**

To display the keyboard help for special key functions press <PF1>, <Help>.

The keyboard functions are used to delete information from a field, move the cursor forward or backward through the fields on the screen, move to the previous or next screen, etc.

Pressing <Return> clears the keyboard help from the screen.

- Enter Sponsor DOB: **10 OCT 1960**
- Enter Sponsor SSN: **611-61-6101**
- Re-enter Sponsor SSN: **611-61-6101**
- Enter Sponsor Patient Category (PATCAT): **A11**, then select USA AD Enlisted
- File the data.

### **DISCUSS THE ACTION BAR ON THE DEERS ELIGIBILITY SCREEN**

The following options display on the DEERS Eligibility Data screen action bar:

- |                          |  |
|--------------------------|--|
| (V)iew more DEERS data   | – View additional data received from DEERS including CHAMPUS dental information.   |
| (H)istorical DEERS       | – View historical DEERS eligibility information.                                   |
| (O)verride Ineligibility | – Enter an override code if the patient's Direct Care eligibility is NOT ELIGIBLE. |
| (P)rint                  | – Print all eligibility information, including the historical data, if available.  |
| (C)ontinue               | – Continue with the process from which you entered the DEERS eligibility check.    |

The system searches the DEERS database, then displays the appropriate DEERS eligibility message at the bottom of the window. For this demonstration, the patient is ineligible and the prompt -Patient Ineligible. Enter override to continue. - displays.

- Press <**Return**> to accept the default to override the ineligibility.

The prompt - Do you want to override the DEERS Ineligibility and continue? NO// - is displayed in the lower section of the screen.

- Override the DEERS Ineligibility and continue: **YES**
- Enter the DEERS Ineligibility Override Code: **2**
- Press <**Return**> to continue.
- Enter Home Phone Number: **(619)555-4938**
- Enter Work Phone Number: **(619)555-9991**
- Enter Patient Address: **1212 MAGNOLIA STREET**
- Enter Patient Sex: **FEMALE**
- Enter Zip Code: **92111**
- Enter Service: <**Return**>
- Enter SSN: <**Return**>
- Enter Command Sec: **PRP**
- Enter Patient Rank: **SSG**
- Enter Sponsor Station/Unit: **FORT EUSTIS**
- Use as is: **YES**
- Enter Duty Address: **2200 FORT EUSTIS BLVD.**
- Enter Zip Code: **23604**
- Enter Duty Phone Number: <**Return**>
- Enter DSM: <**Return**>

- Enter O/P Rec Loc: **MEDICAL RECORDS FILE ROOM**
- Enter O/S Rec Loc: **<Return>**
- Enter Primary Phy: **<Return>**
- Enter Reg Comment: **<Return>**
- Enter Patient wants to be an organ donor: **Y**
- File the data.
- Enter/Edit Allergy Information? NO// **Y**
- Enter at Allergy: **BARBITURATES**
- Enter Comment: **MENTAL CONFUSION**
- Enter at Allergy: **<Return>**
- File the data.
- Press **<Return>** to continue.

## **DISCUSS THE TRANSFER OF REGISTRATION DATA TO FAMILY MEMBERS**

If a Mini Registration (new or a change) is performed for a patient who already has a family member(s) registered in CHCS, the prompt - Select Family Member to Move Demographic Data To - is then displayed.

A selection list of registered family members is displayed. Select the family member(s) whose appointment information you wish to display.

Use the down-arrow key to position the cursor next to the desired family member(s).

When the cursor is positioned, press **<Select>**.

When all selections have been marked, activate the selections by pressing **<Return>**.

The prompt allows you to transfer the personal data that you have just entered for this patient to other family members.

#### EXAMPLE:

You have just entered a new patient into CHCS who has other family members registered at your facility. The address of the new patient is different from that listed for other family members. The system detects the difference in family addresses and presents this prompt for you to make changes to family member registration data, if desired.

The Mini Registration process is now complete. The Demographics Display screen is displayed. The action bar displays Select (F)ull, (M)ini, (N)ew Patient, (C)ontinue, or (Q)uit DEMOGRAPHICS: C//.

- Select the Continue action: **<Return>**
- Enter Arrival Date/Time: **<Return>**
- Enter Chief Complaint: **CHEST PAIN**
- Enter Method of Transit: **POV** (PRIVATELY OWNED VEHICLE)
- Select Appointment Type: EROOM: **<Return>**
- Enter History Obtained From: **PATIENT**
- Select that there is no third party payer: **<Return>**
- Enter Arrival Category: **EMERGENCY**
- Enter MEPRS Code: [MEPRS code]// **<Return>**

#### DISCUSS MEPRS CODES

MEPRS codes determine which clinic is credited, for cost purposes, for this encounter.

The Medical Expense Performance Reporting System (MEPRS) is a cost accounting process to determine the true cost of direct medical care to include amount of work, direct and indirect expenditures, and time/salary expenses of all hospital personnel.

Workload data for inclusion into MEPRS is collected from CHCS.

To differentiate between workload data collected from the various clinics and hospital locations, each medical care entity is assigned a permanent and unique MEPRS code (formerly referred to as a UCA code).

For CHCS use, the MEPRS code is a four-character group (i.e., for the Training Medical Center, the MEPRS code for the Cardiology Clinic is BACA).

The first character of the MEPRS code is the type of medical service primarily rendered by this medical entity as follows:

A = Inpatient

B = Outpatient (such as the Cardiology Clinic - BACA)

C = Dental

D = Ancillary Service (Radiology, pharmacy, etc.)

E = Administrative

F = Support

G = Readiness

Enter ?? to display a valid list of MEPRS codes.

The NER screen is replaced by the NER -- Continuation screen. The NER -- Continuation screen contains the same header information as the previous screen. The NER -- Continuation screen (body) contains the following informational fields:

- Next of Kin
- NOK-Phone
- Command Security
- Military Flying Status.
- Enter Next of Kin: **SHANKS,ALICE**
- Enter NOK-Phone: **(619)555-6789**
- Enter Command Security: **<Return>**
- Enter Military Flying Status: **NO**
- File the data.

- Select to print the SF558 worksheet: <**Return**>
- Display Transparency 1: Sample SF558 Form.
- Enter Device: [default device]// <**Return**>

### **STUDENT LOGON**

- Discuss data cards (i.e., username, password, area, access, and verify codes).
- Log on to the training software and use specified data.

**Practice 1** - Check-in an unregistered patient to the Emergency Room and print the SF558.

## ■ REGISTER A JANE OR JOHN DOE PATIENT

**Scenario:** *An unconscious female in her mid-twenties is brought to the ER. She is not registered at this facility, so you must register her using the John Doe Registration option. Then check her in to the ER.*

You will register a Jane or John Doe patient at this facility by entering specified information.

You will use the Jane or John Doe Registration action from the Registration Menu. The Jane or John Doe Registration option is used to register a patient whose identity is unknown.

There are two ways to register a Jane or John Doe patient:

- Access the Jane/John Doe Registration from the Registration Menu.
- Access the NER option and enter an ampersand (&) <Shift> <7> at the Patient Name prompt. This allows you to perform a Mini Registration for the patient before check-in to the ER.

It is important to register all patients since encounter information cannot be entered on unregistered patients. The system assigns a pseudo FMP/SSN, sponsor name and SSN, and attaches a number to the Jane/John Doe name as a unique identification. It is important to update the patient record once the identity of the Jane/John Doe is known.

- Access the John Doe Registration (7) option on the Registration Menu.

PAS System Menu → **EM** → RER → 7

- Select to add a new John (Jane) Doe: <**Return**>
- Select Patient Name: <**Return**>
- Select FMP: **98** (Civilian Emergency)
- Select SSN: <**Return**>
- Enter Sex: **FEMALE**
- Enter DOB: **1965**

- File the data and exit the option.
- Return to the Emergency Room Menu.

**Practice 2** - Register a Jane or John Doe patient.

## ■ CHECK-OUT A PATIENT FROM THE EMERGENCY ROOM

**Scenario:** *A patient has been treated in the ER for a hot water burn and is ready to be sent home to rest for three days. You must check this patient out of the ER and give the patient follow-up instructions.*

After patients are treated in the ER, they must be checked out. Patients are checked out individually, or as groups, depending on which option you select.

The Check-Out & Patient Instructions (CER) option is used to check-out an individual patient. The patient must be identified with an ER encounter for the active ER activity processing date.

The CER screen is displayed. This is used to record which provider treated this patient, the patient's release condition, and how the patient was checked out or dispositioned. The continuation screen records patient instructions, ER comments, and allows an update of the patient's chief complaint.

The Outpatient Disposition field must be filled in for the system to record the patient as dispositioned. If the field is left blank, the patient is not considered checked out and will remain in the system as undispositioned.

Each outpatient disposition code has been set in the PAS Outpatient Disposition Code table.

Some of the codes are as follows:

- ADMT (Admitted to)
- DOA (Dead on Arrival)
- ERD (Emergency Room Death)
- FULL (Full Duty)
- HOME (Home)
- LWBS (Left Without Being Seen)
- MDU (Modified Duty Until)
- Q12 (Quarters for 12 hours)
- Q24 (Quarters for 24 hours)
- Q48 (Quarters for 48 hours)

- Q72 (Quarters for 72 hours)
- REF (Referred to)
- SCHL (Patient continue to school)
- TRAN (Transferred to another MTF)
- WORK (Patient returned to work)
- X-RAY (Send to X-ray)

Each facility can add additional codes to the list. If the patient is admitted to a ward or clinic, then the disposition is ADMT and the admitting ward or clinic is identified. The patient would be admitted by using the appropriate admitting option.

If the patient is referred to a clinic, the disposition code entered is REF, and the ward or clinic referred to is identified. A patient appointment would be entered by using the appropriate booking option.

If the patient is placed on modified duty, then the disposition is MDU and the modified duty ending date is identified.

The CER procedure ends with the option to print an updated Encounter Form SF558.

The Disposition Processing option is used to process patients with ER encounters on a specified date, from a user-specified start time to 2400. Generally, this task is used to process all patients with ER encounters in the date and time range specified. This option can also be used to identify a specific patient in a date/time range. If undispositioned patients exist from another day, the system informs you by displaying a warning message.

The system identifies all patients within the specified date/time range that have not been checked out. You then process each patient, using the CER screens, until all patients have been processed.

The Disposition Processing option, which can be used to disposition more than one patient, is demonstrated later in this lesson.

When the patient is checked out, using either the CER or Disposition Processing options, then the ER encounter status is changed. The ER clinic appointment is assigned a KEPT or Left Without Being Seen (LWOBS) status, depending on how you set the disposition code.

In the first demonstration of this class, the initial status was Walk-in. When an outpatient disposition is entered, the appointment status is changed from Walk-in to Kept, unless the disposition code is LWOBS. All other codes make the appointment status as Kept.

If a disposition code is not entered, the status remains Walk-in, and that patient is not considered checked out.

In this demonstration, the individual patient is being checked out of the ER.

Once check-out for the patient is complete, the system has sufficient information to generate a complete JCAHO Control Register entry. Generation of this register will be discussed later in this lesson.

The CER option is designed to allow you to check-out patients quickly, using few keystrokes. Default information can be set for [Provider], Date/Time of Release NOW//, and Print SF558 YES//.

- Access the Check-Out & Patient Instructions (CER) option on the Emergency Room Menu.

PAS System Menu → **EM** → CER

- Enter ER Patient Name: **S6504** (SCOTT,ALLAN A)
- Confirm the Patient Name: **<Return>**
- Select the ER episode of care: **1** (21 JUN2001@0610)
- Enter Provider: **<Return>**
- Confirm the Provider: **<Return>**
- Enter Date/Time Seen by the Provider: **T@1100**
- Enter the Date/Time of Release: **T@1200**
- Enter Outpatient Disposition: **HOME**
- Confirm the disposition code selection: **<Return>**
- Enter the Modified Duty Until: **T+3**

- Enter Referred To: **<Return>**
- Enter Priority: **<Return>**
- Enter Admitted To: **<Return>**
- Enter Arrival Category: **EMERGENCY**
- Enter Release Condition: **IMPROVED**
- Enter the Method of Transit: **<Return>**
- Enter Chief Complaint: **<Return>**
- Enter Patient Instructions: **DO NOT COVER DAMAGED AREA.  
LIBERAL APPLICATION OF SILVADINE  
TO AFFECTED AREA TO PREVENT  
INFECTION. RETURN IMMEDIATELY AT  
FIRST SIGN OF INFECTION.**
- Enter ER Comment: **2ND DEG BURN TO LEFT FOOT**
- File the data.
- Select to print the SF558: **<Return>**
- Enter Device [default device]// **<Return>**

**Practice 3** - Check-out a patient from the Emergency Room.

## ■ UPDATE A PATIENT'S EMERGENCY ROOM ENCOUNTER INFORMATION

**Scenario:** *A patient with a broken foot was seen in the ER. His release condition is noted as improved. You gave him instructions to apply ice to his foot to keep down the swelling. Update the encounter information.*

Patient data often changes. Using the Full ER Encounter (FER) option allows you to use one option to update all of the patient's data. Being familiar with this option can save you steps (and time) in your job.

Once the new patient data has been entered into the system using the NER option, there are several ways you can update or edit the information:

- Enter/edit a problem, procedure, and diagnosis, using the Problem, Procedure, & Diagnosis Enter/Edit (PER) option.
- Update appointment history and encounter data, using the Update, Appt History Encounter Data (UER) option.
- Check-out the patient, providing him/her with instructions (covered in the last demonstration), using the CER option.

You can select the FER option to update all three activities above.

The options you choose depend upon the amount of data you have to edit.

For example, if only the problem, procedure, or diagnosis fields need to be edited, select the PER option. To edit more than one of the areas just stated, select the FER option. In this lesson, you will update specified patient data for an encounter that occurred the previous day using the FER option.

## DISCUSS ANTEDATING ENCOUNTER INFORMATION

There are instances when you may need to update patient information for an ER encounter that occurred before today. To perform this operation, you must first change the system activity date to the date that the ER encounter actually occurred.

### EXAMPLE:

Today is [CURRENT DATE]. On the previous day, patient SANDERS,ALLAN was treated in the ER, then released. Today, you have received supplemental information concerning this encounter that must be entered into the system.

Using the Activity Date and ER Clinic Edit (AER) option on the Emergency Room Menu, you change the activity date to the date of the encounter (T-1) to enter this information.

When finished entering the backdated information, you must remember to change the activity date back to today.

- Access the Activity Date and ER Clinic Edit (AER) option on the Emergency Room Menu.

PAS System Menu → **EM** → AER

- Select Clinic: **ER11**
- Enter ER activity date: **T-1**
- Access the Full ER Encounter (FER) option on the Emergency Room Menu.

PAS System Menu → **EM** → FER

- Enter ER Patient Name: **S6501** (SANDERS,ALLAN A)
- Select the patient: **1**
- Enter Provider: **<Return>**
- Confirm the Provider: **<Return>**
- Enter Date/Time seen by the Provider: **T-1@1200**
- Enter the Date/Time of Release: **T-1@1500**
- Enter Outpatient Disposition: **HOME**
- Confirm the disposition code selection: **<Return>**
- Enter the Modified Duty Until: **T+3**
- Enter Referred To: **<Return>**
- Enter Priority: **<Return>**
- Enter Admitted To: **<Return>**
- Enter Arrival Category: **EMERGENCY**
- Enter Release Condition: **IMPROVED**

- Enter the Method of Transit: **<Return>**
- Enter Chief Complaint: **<Return>**
- Enter Patient Instructions: **STAY OFF OF FOOT. KEEP FOOT ELEVATED WHEN POSSIBLE. APPLY ICE.**
- Enter ER Comment: **<Return>**
- File the data.
- Select not to print the SF558: **N**
- Enter Appointment Type: **<Return>**
- Enter Appointment Status: **<Return>**
- Enter MEPRS Code: **<Return>**
- Enter Secondary Provider: **<Return>**
- Select Trackable Entity: **PAIR OF CRUTCHES**
- Confirm the trackable entity entry: **<Return>**
- Enter Next of Kin: **<Return>**
- Enter NOK-Phone: **<Return>**
- Enter Command Security: **<Return>**
- Enter Military Flying Status: **<Return>**
- File the data.
- Select Diagnosis: **824.9**
- Enter at Diagnosis: **<Return>**
- Enter at Description: **<Return>**
- Enter at Job Related: **NO**
- Select Diagnosis (Free Text): **BROKEN ANKLE**
- Confirm Diagnosis (Free Text) Selection: **<Return>**
- Exit the Diagnosis (Free Text) Field: **<Return>**

- Enter Chief Complaint: **<Return>**
- Enter Patient Instructions: **<Return>**
- Exit the Patient Instructions Field: **<Return>**
- Select Problem Code: **<Return>**
- Select Procedure: **<Return>**
- Select Procedure (Free Text): **CAST**
- Confirm Procedure (Free Text) Selection: **<Return>**
- File the data.

**Practice 4** - Update a patient's Emergency Room encounter information.

## ■ VIEW PAST AND FUTURE APPOINTMENTS, AND WAIT LIST REQUESTS FOR A SPECIFIED PATIENT AND FAMILY MEMBER

**Scenario:** *A cardiac patient has arrived at the ER via ambulance and needs immediate attention. You discover that this patient has been seen previously at this facility and you need to see this patient's appointment history.*

Sometimes, patients will not remember the name of their provider, or will request a list of future appointments. The View Patient Appointment History (VER) option is a quick method of looking up a patient's past and future (pending) appointments and Wait List requests. After viewing the appointment history for the patient, you can quickly check appointment histories for other family members.

- Access the Activity Date and ER Clinic Edit (AER) option on the Emergency Room Menu.

PAS System Menu → **EM** → AER

- Select Clinic: **ER11**
- Enter ER Activity Date: **<Return>**
- Access the View Patient Appointment History (VER) option on the Emergency Room Menu.

PAS System Menu → **EM** → VER

- Refer to Quick Reference Guide: Display Patient Appointments.
- Enter Patient Name: **S6501** (SANDERS,ALLAN A)
- Select the patient: **1** (SANDERS,ALLAN A)
- Select Appointments by Past Appointments option: **P**
- Enter at Device: **<Return>**
- Enter at Right Margin: **<Return>**
- Press **<Return>** (to continue).
- Select to display or print appointment history of another family member: **Y**

- Select family member: **1** (SANDERS,ANDY)
- Select the Past Appointments action: **P**
- Enter at Device: **<Return>**
- Enter at Right Margin: **<Return>**
- Press **<Return>** (to continue).
- Select not to display or print appointment history of another family member:  
**<Return>** (to exit the option).

**Practice 5** - View past and future appointments, and Wait List requests for a specified patient and family member.

## ■ REPRINT THE SF558

**Scenario:** *The printer jammed when you were printing the encounter form so you must print another one.*

The Encounter Form SF558 worksheet is an 80-column worksheet that contains information from processing a new ER encounter. All of the information entered at that time is recorded on the SF558. The SF558, with the provider's handwritten comments, is the legal encounter form. It must be filed in the patient's record.

For this demonstration, you will use the SER option on the Emergency Room Menu to print the Encounter Form for a specific patient on a specified device.

- Access the SF558 Print (SER) option on the Emergency Room Menu.

PAS System Menu → **EM** → SER

- Select ER Patient Name: **S6504** (SCOTT,ALLAN A)
- Confirm selection: <**Return**>
- Select the encounter: **1**
- Enter at Device: **HOME**, then <**Hold Screen**>
- Release the SF558 Worksheet: <**Hold Screen**>

**Practice 6** - Reprint the SF558.

## ■ GENERATE A PARTIAL JCAHO CONTROL REGISTER

**Scenario:** *Your supervisor has requested that you generate today's JCAHO Control Register for the ER.*

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Register Log lists patient encounters in ERs at the facility for a previous date or the current date. A partial ER log can be generated that shows appointments up to the designated time before day's end. The log is sorted by hospital location: clinic, division, or entire facility, then appointment time.

PAS can support a facility with more than one ER. To generate the log, identify which location should be reported in the log. Identify which location by selecting a range of locations from the action bar - Select (C)linic, (D)ivision, or (A)ll for Entire Facility - when appropriately displayed. If you select (C)linic, you can choose from an alphabetized list of Emergency Rooms in the database.

Identify which location(s) to record by selecting the clinic and then entering a double question mark (??) to display the alphabetized list of Emergency Room locations in the database. Select those you want.

Next, identify the date and time of the log. The date indicates appointment dates, and includes the ending or last appointment time for listed appointments. An appointment date is required. If no appointment time is listed, the current time is used.

The JCAHO Control Register Log is a 132-column report and generally requires an appropriate printer identification. However, when the device prompt displays, enter PAS WIDEFORM to print the report on an 80-column slave printer attached to your terminal. The report prints in a compressed format.

## DISCUSS THE REGISTRATION MENU AND THE MANAGEMENT REPORTS MENU

The Registration Menu and the Management Reports Menu on the Emergency Room Menu have forms and reports used in the ER.

The Registration Menu allows you to generate the following items:

- Registration forms
- Embossed cards
- Requests for medical records.

The registration form contains all of the patient's registration information. The embossed card is the patient's identification card. The Request a Record option allows you to pull patient medical records immediately instead of waiting for the usual, or scheduled, pull time.

The process of generating the registration form is similar to that for generating the SF558 Encounter Form, and is a straightforward procedure. Enter the clinic (if applicable), patient name, and print parameters.

The Management Reports Menu (MER) contains three options:

- Clinic Workload Report
- End-of-Day Processing/Editing
- Trackable Entity Report.

## **DISCUSS THE CLINIC WORKLOAD REPORT**

The Clinic Workload Report totals encounters for a specific clinic and for a specific date range in the following order:

- The first section of the report is the subtotal and total by appointment types.
- The second section is the subtotal and total by provider for each appointment type.
- The third section is the statistics by patient code and category description.
- The fourth section is the total for the clinic by MEPRS code.

## **DISCUSS THE END-OF-DAY PROCESSING/EDIT OPTION**

The End-of-Day Processing/Edit option allows you to edit, modify, or update appointment history data including the status of daily encounters for each ER clinic and ER provider.

This option provides the means by which the computer database is updated to reflect what has really happened in the ER clinic and which data is reported in numerous statistical reports.

This option allows you to update or correct patient appointment history data and review the status of daily encounters.

This option enables you to specify whether an appointment status is Walk-In, Telephone-Consult, Sick-Call, Occasion of Service (OCC-SVC), Admin, or Left Without Being Seen (LWOBS).

This option allows you to update the appointment status of any patient who was checked in manually.

Updates must be completed within seven days of the appointment. After seven days, only supervisory personnel with the required security key will be able to perform end-of-day processing.

### **Discuss the Trackable Entity Report**

The Trackable Entity Report displays all trackable entity data by clinic or division.

This report displays the date, ER log #, patient name and telephone number, FMP/SSN, and work telephone number for every trackable entity loaned from a clinic.

The following demonstration will show you how to generate a partial register using the JCAHO Control Register Print option.

- Access the JCAHO Control Register Print (JER) option on the Emergency Room Menu.

PAS System Menu → **EM** → JER

- Refer to Quick Reference Guide: End-of-Day Processing.
- Select the Clinic option: **C**
- Enter ER Clinic: **ER11**
- Select ER Log Start Date/Time: **<Return>**
- Select ER Log Stop Date/Time: **<Return>**
- Select Device: **HOME**

**Practice 7** - Generate a partial JCAHO Control Register Log.

## ■ DISPOSITION ALL PATIENTS FROM THE EMERGENCY ROOM

**Scenario:** *ER personnel have checked in several patients in the last several hours. No one has had an opportunity to disposition any of the patients until now. You must now disposition the patients.*

The steps for dispositioning all patients at once are the same as the steps you use to check-out patients individually (this was discussed during the third demonstration of this class), except as follows:

The system automatically calls up each patient for you, instead of you having to enter each patient's name one at a time. The system keys off an entry in the Outpatient Disposition field. That is, if the Outpatient Disposition field is not filled in, the system locates and presents the patient data display for disposition at this time. If the Outpatient Disposition field is filled in, the system bypasses that patient.

**Note:** Workload reporting for the ER is counted based on information in the Appointment Status field, not the Outpatient Disposition field.

There is no SF558 Encounter Form to generate.

**Note:** The Emergency Room Menu is displayed.

- Access the Disposition Processing (DER) option on the Emergency Room Menu.

PAS System Menu → **EM** → DER

- Select Start Date/Time to Begin Processing: **<Return>**
- Enter ER Patient Name: **<Return>**
- Enter Provider: **<Return>** (QUURN)
- Confirm the Provider: **<Return>**
- Enter Date/Time Seen by the Provider: **T@1100**
- Enter the Date/Time of Release: **T@1130**
- Enter Outpatient Disposition: **HOME**
- Confirm the disposition code selection: **<Return>**
- Enter the Modified Duty Until: **<Return>**
- Enter Referred To: **<Return>**

- Enter Priority: **ROUTINE**
- Enter Admitted To: **<Return>**
- Enter Arrival Category: **<Return>**
- Enter Release Condition: **IMPROVED**
- Enter the Method of Transit: **<Return>**
- Enter Chief Complaint: **<Return>**
- Enter Patient Instructions: **<Return>**
- Enter ER Comment: **<Return>**
- File the data.
- Continue to disposition patients: **<Return>**
- Enter Provider: **<Return>** (QUURN)
- Confirm the Provider: **<Return>**
- Enter Date/Time Seen by the Provider: **T@1130**
- Enter the Date/Time of Release: **T@1300**
- Enter Outpatient Disposition: **HOME**
- Confirm the disposition code selection: **<Return>**
- Enter the Modified Duty Until: **<Return>**
- Enter Referred To: **<Return>**
- Enter Priority: **ROUTINE**
- Enter Admitted To: **<Return>**
- Enter Arrival Category: **<Return>**
- Enter Release Condition: **IMPROVED**
- Enter the Method of Transit: **<Return>**
- Enter Chief Complaint: **<Return>**

- Enter Patient Instructions: <**Return**>
- Enter ER Comment: <**Return**>
- File the data.
- Exit the option: <^>
- Return to the PAS System Menu.

**Practice 8** - Disposition specified patients from the Emergency Room using the Disposition Processing option.

## ■ DISCUSS EMERGENCY ROOM PARAMETERS

**Scenario:** *You have been directed to add a new method of transit to your ER clinic's list of ER parameters. You need to update the file to reflect the new method of transit.*

- Access the File/Table Maintenance Menu (FILE) option on the Scheduling Supervisor Menu.

### **PAS System Menu → S → FILE**

Not all users can access the File/Table Maintenance Menu. Profile parameters control which users are allowed to access and use this menu. The parameters are called security keys.

## **DISCUSS SECURITY KEYS**

Security keys and processing locks can be compared to keys to locked office doors. Some staff members may have a key to unlock the door to the office suite. Those with more authority will have keys to the suite and their own private office. The office manager distributes keys according to use, just as the system manager assigns security keys to CHCS users.

Security keys are created by the system manager at your facility. PAS security locks restrict access to certain PAS functions including the File/Table Maintenance Menu. Each subsystem usually has its own set of security keys which are assigned to certain users.

As you learned in the CHCS Orientation class, security locks/keys are also used to restrict the use of certain menus and options. Only those users who hold the appropriate keys can access the menus and options.

After logging on to the system, if the File/Table Maintenance Menu is not listed on the Scheduling Supervisor Menu on your terminal, then you do not have the security key to access it.

Security keys are not defined in the PAS profiles; these locks are built into the system.

## **DISCUSS THE FILE/TABLE MAINTENANCE MENU**

The options in the File/Table Maintenance Menu allow you to create new clinics/ERs, maintain PAS tables, and define the PAS mailers used for Wait List processing.

Each table contains codes and the meaning of the codes. The table entries are displayed when you enter ?? at the related field. The PAS-specific tables used in ER processing are:

- Method of Transit (FILE → MFIL)
- Outpatient Disposition (FILE → OFIL)
- Trackable Entity (FILE → TFIL).

Through these table options, you can enter outpatient disposition and trackable entities parameter types, or edit current ones entered by your facility.

The codes listed in these tables apply to the entire facility. The Method of Transit table identifies codes for all possible methods by which a patient could be transported to an ER (i.e., AMB = ambulance).

The Outpatient Disposition table identifies codes that describe the method of patient disposition from the ER (i.e., HOME = sent home). Some values are pre-loaded, and additional entries may be made by site personnel.

The Trackable Entities table contains codes that describe all trackable reusable materials and equipment loaned to patients (i.e., crutches). All values must be added by site personnel.

PAS software allows you to maintain files and tables without relying on the database manager. However, data delivered with CHCS software cannot be edited, deleted, or deactivated. New codes can be added to the PAS tables and edited by site personnel. The maintenance procedure is the same for each table. The number of fields that can be edited depends on the table.

The Patient Appointment and Scheduling Reference Manual lists menus and menu definitions for PAS-maintainable tables.

**Practice** - There is no practice for this objective.

#### **IV. CLOSURE**

Do you have any questions about the concepts covered in this class?

In summary, the following content was presented:

- Checking in a patient to the Emergency Room and printing the SF558.
- Registering a Jane or John Doe patient.
- Checking out a patient from the Emergency Room.
- Updating a patient's Emergency Room encounter information.
- Viewing past and future appointments, and Wait List requests for a specified patient and family member.
- Reprinting the SF558.
- Generating a partial JCAHO control register.
- Dispositioning all patients from the Emergency Room.
- Discussing Emergency Room parameters.

Remember that Procedure Flowcharts, Menu Diagrams and Definitions, Quick Reference Guides, output samples, and a Subsystem Glossary are included in the Reference Manual, and may be used to complete the Master Practice.

This concludes the PAS: Emergency Room Processing class. You now have the opportunity to demonstrate proficiency in the topics or skills presented.

Please complete the Class Critique before leaving the classroom.

Thank you for attending.

#### **Master Practice**

# **PAS: EMERGENCY ROOM PROCESSING**

## **Section 2 Practices**

## **PAS: EMERGENCY ROOM PROCESSING**

### **Section 2. Practices**

#### **PRACTICE GUIDELINES**

The information you need to complete each practice is supplied in the instructions, scenarios, and associated data cards. Data cards are found in Section 4 of the Student Guide.

Notify the presenter when directed to do so in the practice. This allows the presenter to verify that you have successfully completed an activity.

You may use any reference materials available in the classroom to complete your practices.

You may ask questions or request assistance at any time during the practices.

Device identifiers are site-specific, and will be provided by the presenter.

Refer to your data cards for any specific information that is required, but not listed within the practice scenario or listed data.

Information is only specified for those fields and prompts which require specific data entry. To advance past fields/prompts which are not specified, enter data you know to be correct, or press <Return>.

The practices for this class must be completed in the order in which they are presented. Please complete all parts of each practice before proceeding.

**NOTE TO PRESENTER:** Tell students whether they may write in their Student Guides while performing the practices/Master Practice. If the Student Guides must be used for another class session, you may not want students to write in their documents.

## **PAS: EMERGENCY ROOM PROCESSING**

**Practice 1** - Check-in an unregistered patient to the Emergency Room and print the SF558.

**INSTRUCTIONS:** You have approximately 15 minutes to complete this practice.

**Scenario:** *An active duty officer on leave has just arrived in the ER complaining of severe chest pains. She was driven to the ER by a family member who is her next of kin. She is not registered at your facility, but needs to be seen by a provider immediately in the ER.*

Access the New ER Patient Enter (NER) option on the Emergency Room Menu.

Select Clinic: **[clinic]**

Enter ER activity date: **<Return>**

Register the patient:

Select Patient/Sponsor Name: **[patient/sponsor identifier]**

**Note:** Use Correct Patient Lookup procedures to enter this patient.

Enter Sponsor FMP: **20**

Enter Sponsor DOB: **10 OCT 60**

Enter Sponsor SSN: **[SSN]**

Enter Sponsor Patient Category: **A11** (USA AD Officer)

File the data.

Override the DEERS ineligibility and continue: **6** (Patient has valid ID within 120 days)

Enter Patient Sex: **FEMALE**

Enter Command Sec (Command Security): **PRP**

Enter Patient Rank: **CAPTAIN**

Enter Sponsor Station/Unit: **FORT EUSTIS**

Use as is.

Enter O/P Rec Location: **MEDICAL RECORDS FILE ROOM**

Enter Patient wants to be an organ donor: **Y**

File the data.

Enter/Edit Allergy Information: **PROTEIN COMPLEX**

Enter Allergy Comment: **VOMITING**

File the data.

## **PAS: EMERGENCY ROOM PROCESSING**

### **Practice 1 (continued)**

Continue: **<Return>**

Check-in the registered patient to the ER:

Arrival Date/Time: **<Return>**  
Enter Chief Complaint: **CHEST PAIN**  
Enter Method of Transit: **POV**  
Appointment Type: **<Return>**  
Enter History Obtained From: **PATIENT**  
Third Party Payer: **<Return>**  
Enter Arrival Category: **EMERGENCY**  
MEPRS Code: **<Return>**  
Enter Next of Kin: **[next of kin]**  
Enter NOK-Phone: **[NOK phone #]**  
Command Security: **<Return>**  
Enter Military Flying Status: **NO**

File the data.

Print the SF558 worksheet:

Enter at Device: **HOME**

As soon as the SF558 displays and begins to scroll, press **<Hold Screen>** on your keyboard. Observe that the Hold Screen indicator (green light) on your terminal is illuminated.

Notify the presenter when you have generated Encounter Form SF558 for the specified patient. Allow the presenter to view the encounter form before you continue.

The Emergency Room Menu displays.

## **PAS: EMERGENCY ROOM PROCESSING**

### **Practice Evaluation Criteria**

**Practice 1** - Check-in an unregistered patient to the Emergency Room and print the SF558.

**Verify** that the students have properly checked-in an unregistered patient to the Emergency Room using the data contained in the scenario and in their data cards by viewing each student's terminal.

**Determine** that the students have entered the following information:

Patient/Sponsor Name: **[student data card]**  
Sponsor DOB: **10 OCT 1960**  
Sponsor/Patient Category: **A11**  
Patient Sex: **FEMALE**  
Command Security: **PRP**  
Patient Rank: **CAPTAIN**  
Sponsor Station/Unit: **FORT EUSTIS**  
O/P Record Location: **MEDICAL RECORDS FILE ROOM**  
Allergies: **BARBITURATES**  
Chief Complaint: **CHEST PAIN**  
Method of Transit: **POV**  
History Obtained From: **PATIENT**  
Arrival Category: **EMERGENCY**

**Review** Encounter Form SF558 for the specified patient with the students.

## **PAS: EMERGENCY ROOM PROCESSING**

**Practice 2** - Register a Jane or John Doe patient.

**INSTRUCTIONS:** You have approximately 5 minutes to complete this practice.

**Scenario:** *A female, approximately 45 years old, is brought into the ER. She has been severely injured in an automobile accident, and she is unconscious. She has no identification on her.*

Access the John Doe Registration (7) option on the Registration Menu.

Add a new Jane Doe to the system.

Select Patient Name: <**Return**>

Select FMP: <**Return**>

Select SSN: <**Return**>

Enter Sex: **FEMALE**

Enter DOB: **1955**

Before you file the data, notify the presenter. Allow the presenter to view the John Doe registration data on your screen before continuing.

File the data.

Return to the Emergency Room Menu.

## **PAS: EMERGENCY ROOM PROCESSING**

### **Practice Evaluation Criteria**

**Practice 2** - Register a Jane or John Doe patient.

**Verify** that the students have properly registered a Jane or John Doe patient using the data contained in the scenario by viewing each student's terminal.

**Determine** that the students have entered the following information:

Sex: **FEMALE**

DOB: **1955**

**Review** the John Doe registration data with the students.

## **PAS: EMERGENCY ROOM PROCESSING**

**Practice 3** - Check-out a patient from the Emergency Room.

**INSTRUCTIONS:** You have approximately 15 minutes to complete this practice.

**Scenario:** *A patient who checked into the ER for chest pains was diagnosed with myocardial infraction and will be admitted to the coronary care unit. The patient will be off duty for three months. The patient's release condition from the ER is unchanged. You will need to print the patient's Encounter Form SF558 worksheet.*

Access the Check-out & Patient Instructions (CER) option on the Emergency Room Menu.

Select Patient: **[patient identifier]**

Complete the CER screens:

Confirm Provider: **<Return>**  
Enter Date/Time Seen by the Provider: **T@1100**  
Enter the Date/Time of Release: **T@1200**  
Enter Outpatient Disposition: **ADMT**  
Enter the Modified Duty Until: **T+90**  
Referred to: **<Return>**  
Enter Priority: **<Return>**  
Enter Admitted To: **5E (CARDIAC CARE UNIT)**  
Enter Arrival Category: **EMERGENCY**  
Enter Release Condition: **UNCHANGED**  
Method of Transit: **<Return>**  
Chief Complaint: **<Return>**  
Patient Instructions: **<Return>**  
Enter ER Comment: **PENDING LAB RESULTS**

Notify the presenter when you have finished entering data. Allow the presenter to view your screen before you file the data.

File the data.

Generate Encounter Form SF558 worksheet:

Enter at Device: **[device]**

The Emergency Room Menu displays.

## **PAS: EMERGENCY ROOM PROCESSING**

### **Practice Evaluation Criteria**

**Practice 3** - Check-out a patient from the Emergency Room.

**Verify** that the students have properly checked-out a patient from the Emergency Room using the data contained in the scenario and in their data cards by viewing each student's terminal.

**Determine** that the students have entered the following information:

Patient: **[student data card]**  
Provider: **[student data card]**  
Date/Time Seen by the Provider: **T@1100**  
Date/Time of Release: **T@1200**  
Outpatient Disposition: **ADMT**  
Modified Duty Until: **T+90**  
Admitted To: **5E**  
Arrival Category: **EMERGENCY**  
Release Category: **UNCHANGED**  
ER Comment: **PENDING LAB RESULTS**

**Review** the patient check-out information with the students.

## **PAS: EMERGENCY ROOM PROCESSING**

**Practice 4** - Update a patient's Emergency Room encounter information.

**INSTRUCTIONS:** You have approximately 15 minutes to complete this practice.

**Scenario:** *A patient came into the ER yesterday after falling off a bicycle. The patient was sent to X-ray in a wheelchair for a dislocated shoulder. According to the SF558 Encounter Form, this patient was referred to orthopedics for treatment. The patient was instructed to go home and apply ice to the shoulder.*

Access the Activity Date and ER Clinic Edit (AER) option on the Emergency Room Menu.

Select Clinic: **[clinic]**

Enter ER Activity Date: **20 JUN 2001**

Access the Full ER Encounter (FER) option on the Emergency Room Menu.

Enter ER Patient Name: **[patient identifier]**

Enter CER:

Confirm Provider: **<Return>**

Enter Date/Time Seen by the Provider: **T-1@1200**

Enter the Date/Time of Release: **T-1@1500**

Enter Outpatient Disposition: **HOME**

Enter the Modified Duty Until: **T+3**

Referred to: **AORTHO**

Enter Priority: **ROUTINE**

Admitted to: **<Return>**

Enter Arrival Category: **EMERGENCY**

Enter Release Condition: **IMPROVED**

Method of Transit: **<Return>**

Notify the presenter when you are finished entering data. Allow the presenter to view your screen before you continue.

Chief Complaint: **<Return>**

Enter Patient Instructions: **APPLY ICE PACK**

ER Comment: **<Return>**

Notify the presenter when you are finished entering data. Allow the presenter to view your screen before you continue.

File the data.

## **PAS: EMERGENCY ROOM PROCESSING**

### **Practice 4** (continued)

Do not generate Encounter Form SF558 worksheet.

Update appointment history and encounter data:

Enter Appointment Type: **<Return>**  
Enter Appointment Status: **<Return>**  
MEPRS Code: **<Return>**  
Secondary Provider: **<Return>**  
Select Trackable Entity: **WHEELCHAIR**

Notify the presenter when you are finished entering data. Allow the presenter to view your screen before you continue.

Next of Kin: **<Return>**  
NOK-Phone: **<Return>**  
Command Security: **<Return>**  
Enter Military Flying Status: **<Return>**

File the data.

Enter problem, procedure, and diagnosis (PER) data:

Select Diagnosis: **831.09 (DISLOCATED SHOULDER)**  
Diagnosis: **<Return>**  
Description: **<Return>**  
Job Related: **NO**  
Select Diagnosis: **<Return>**  
Select Diagnosis (Free Text): **DISLOCATED SHOULDER**  
Confirm Diagnosis: **<Return>**

Notify the presenter when you are finished entering data. Allow the presenter to view your screen before you continue.

Chief Complaint: **<Return>**  
Patient Instructions: **<Return>**  
Problem Code: **<Return>**  
Select Procedure: **<Return>**  
Select Procedure (Free Text): **IMMOBILIZE ARM AND SHOULDER  
WITH SLING**  
Confirm Procedure: **<Return>**

## **PAS: EMERGENCY ROOM PROCESSING**

### **Practice 4** (continued)

Notify the presenter when you are finished entering data. Allow the presenter to view your screen before you continue.

File the data.

The Emergency Room Menu displays.

## **PAS: EMERGENCY ROOM PROCESSING**

### **Practice Evaluation Criteria**

**Practice 4** - Update a patient's Emergency Room encounter information.

**Verify** that the students have properly checked-out a patient from the Emergency Room using the data contained in the scenario and in their data cards by viewing each student's terminal.

**Determine** that the students have entered the following information:

Clinic: **[student data card]**  
ER Activity Date: **20 JUNE 2001**  
Patient: **[student data card]**  
Provider: **[student data card]**  
Date/Time Seen by the Provider: **T-1@1200**  
Date/Time of Release: **T-1@1500**  
Outpatient Disposition: **HOME**  
Modified Duty Until: **T+3**  
Referred To: **AORTHO**  
Priority: **ROUTINE**  
Arrival Category: **EMERGENCY**  
Release Condition: **IMPROVED**  
Patient Instructions: **APPLY ICE PACK**  
Trackable Entity: **WHEELCHAIR**  
Select Diagnosis: **831.09**  
Select Diagnosis (Free Text): **DISLOCATED SHOULDER**  
Job Related: **NO**  
Procedure (Free Text): **IMMOBILIZE ARM AND SHOULDER WITH SLING**

**Review** the Emergency Room encounter information with the students.

## **PAS: EMERGENCY ROOM PROCESSING**

**Practice 5** - View past and future appointments, and Wait List requests for a specified patient and family member.

**INSTRUCTIONS:** You have approximately 10 minutes to complete this practice.

**Scenario:** *A patient and child have arrived in the ER needing urgent care. The patient and child are registered in your facility, but they do not have their records with them. You want to find out about their appointment history. A quick way to do this is to view past and future appointment data for these patients.*

**Note:** Patients may or may not have both past and future appointment history. However, patients will have at least past or future appointment history.

Access the Activity Date and ER Clinic Edit (AER) option on the Emergency Room Menu.

Select Clinic: **[clinic]**

Select ER Activity Date: **<Return>**

Access the View Patient Appointment History (VER) option on the Emergency Room Menu.

Display appointments for a patient:

Enter Patient Name: **[first family member]**

Select the Past Appointments option.

Enter at Device: **HOME**

Notify the presenter when you have the patient's appointment history on the screen. Allow the presenter to view your screen before continuing.

Select to display or print appointment history of another family member:

Select Family Member: **[second family member]**

Select the Past Appointments option.

Enter at Device: **HOME**

## **PAS: EMERGENCY ROOM PROCESSING**

### **Practice 5 (continued)**

Notify the presenter when you have the patient's appointment history on the screen. Allow the presenter to view your screen before continuing.

Select to display or print future appointments of another family member:

Enter Patient Name: **[first family member]**

Select the Future Appointments option.

Enter at Device: **HOME**

Notify the presenter when you have the patient's appointment history on the screen. Inform the presenter of the name of the provider for the first appointment listed for this patient. Allow the presenter to view your screen before continuing.

Select to display or print future appointment of another family member:

Select family member: **[second family member]**

Select the Future Appointments option.

Enter at Device: **HOME**

Notify the presenter when you have the patient's appointment history on the screen. Inform the presenter of the name of the provider for the first appointment listed for this patient. Allow the presenter to view the screen before continuing.

Select not to display or print appointment history of another family member.  
(This will exit the option.)

The Emergency Room Menu displays.

## **PAS: EMERGENCY ROOM PROCESSING**

### **Practice Evaluation Criteria**

**Practice 5** - View past and future appointments, and Wait List requests for a specified patient and family member.

**Verify** that the students have properly viewed past and future appointments, and Wait List requests for the specified patient and family member, using the data contained in the scenario and in their data cards by viewing each student's terminal.

**Determine** that the students have entered the following information:

– For Past appointments:

Clinic: **[student data card]**

Patient: **[student data card]**

Family Member: **[student data card]**

– For Future appointments and Wait List requests:

Patient: **[student data card]**

Family Member: **[student data card]**

**Review** the appointment history screens with the students.

## **PAS: EMERGENCY ROOM PROCESSING**

**Practice 6** - Reprint the SF558.

**INSTRUCTIONS:** You have approximately 5 minutes to complete this practice.

**Scenario:** *A patient's Encounter Form SF558 has become soiled, so the ER clerk decides to generate another.*

Access the SF558 Print (SER) option on the Emergency Room Menu.

Select ER Patient Name: **[patient identifier]**

Enter at Device: **HOME**

As soon as the SF558 is displayed and begins to scroll, press the <Hold Screen> on your keyboard. Observe that the Hold Screen indicator (green light) on your keyboard is illuminated.

Notify the presenter when you have displayed the encounter form and allow the presenter to view the encounter form before continuing.

After the presenter has viewed your screen, verify that the Hold Screen indicator on your keyboard is extinguished. If the Hold Screen indicator is still illuminated, press <Hold Screen> again.

The Emergency Room Menu displays.

## **PAS: EMERGENCY ROOM PROCESSING**

### **Practice Evaluation Criteria**

**Practice 6** - Reprint the SF558.

**Verify** that the students have properly reprinted Encounter Form SF558 for the specified patient using the data contained in the scenario and in their data cards by viewing each student's terminal.

**Determine** that the students have generated the SF558 for the following patient:

Patient: **[student data card]**

**Review** the Encounter Form SF558 with the students.

## **PAS: EMERGENCY ROOM PROCESSING**

**Practice 7** - Generate a partial JCAHO Control Register Log.

**INSTRUCTIONS:** You have approximately 5 minutes to complete this practice.

Generate a register log for one specified ER and a specified ER log date/time, and print it on a specified device.

***Scenario:*** *You need to print a JCAHO Control Register for your ER clinic showing appointments up to the current time.*

Access the JCAHO Control Register Print (JER) option on the Emergency Room Menu.

Select the Clinic action.

Enter ER Clinic: **[clinic]**

Select ER Log Start Date/Time: **T@0001**

Select the ER Log STOP DATE/TIME default for now.

Notify the presenter when you have finished entering data. Allow the presenter to view your work before you continue.

Select Device: **[device assigned by presenter]**

The Emergency Room Menu displays.

## **PAS: EMERGENCY ROOM PROCESSING**

### **Practice Evaluation Criteria**

**Practice 7** - Generate a partial JCAHO Control Register Log.

**Verify** that the students have properly generated a partial JCAHO Control Register Log for the specified clinic using the data contained in the scenario and in their data cards by viewing each student's terminal.

**Determine** that the students have entered the following information:

ER Clinic: **[student data card]**

ER Log Start Date/Time: **T@0001**

ER Log Stop Date/Time: **<Return>**

**Review** the partial JCAHO Control Register Log with the students.

## **PAS: EMERGENCY ROOM PROCESSING**

**Practice 8** - Disposition specified patients from the Emergency Room using the Disposition Processing option.

**INSTRUCTIONS:** You have approximately 15 minutes to complete this practice.

**Scenario:** *You need to disposition patients who have checked into the ER since 0800. When you check your log, you observe that there are two patients to disposition.*

**Note:** Although, in most cases, there are actually more than two patients in the database that can be dispositioned, enter disposition data for only the two patients identified on your data card.

Access the Disposition Processing (DER) option on the Emergency Room Menu.

Select Start Date/Time to Begin Processing: **<Return>**

Select the All Patients default.

Disposition the first patient:

ER Patient Name: **[first patient identifier]**  
Verify Provider: **[provider]**  
Enter Date/Time Seen by the Provider: **[date/time seen]**  
Enter the Date/Time of Release: **[date/time released]**  
Enter Outpatient Disposition: **HOME**  
Enter Priority: **ROUTINE**  
Enter Release Condition: **IMPROVED**

Notify the presenter when you have finished entering data. Allow the presenter to view your screen before you file the data for the first patient.

File the data.

Continue to disposition patients using the DER option.

## **PAS: EMERGENCY ROOM PROCESSING**

### **Practice 8** (continued)

Disposition the second patient:

ER Patient Name: **[second patient identifier]**  
Enter Provider: **[provider]**  
Enter Date/Time Seen by the Provider: **[date/time seen]**  
Enter the Date/Time of Release: **[date/time of release]**  
Enter Outpatient Disposition: **HOME**  
Enter Priority: **ROUTINE**  
Enter Release Condition: **IMPROVED**

Notify the presenter when you have finished entering data. Allow the presenter to view your screen before you file the data for the second patient. After completion of data entry for the second patient, at the prompt - Press <Return> to continue, type <^> to escape.

Select escape: <^>

Return to the PAS System Menu.

## **PAS: EMERGENCY ROOM PROCESSING**

### **Practice Evaluation Criteria**

**Practice 8** - Disposition specified patients from the Emergency Room using the Disposition Processing option.

**Verify** that the students have properly dispositioned specified patients using the data contained in the scenario and in their data cards by viewing each student's terminal.

**Determine** that the students have entered the following information for both patients being dispositioned:

Patient Names: **[student data card]**  
Provider: **[student data card]**  
Date/Time Seen by the Provider: **[student data card]**  
Date/Time of Release: **[student data card]**  
Outpatient Disposition: **HOME**  
Priority: **ROUTINE**  
Release Condition: **IMPROVED**

**Review** the disposition information with the students.

# **PAS: EMERGENCY ROOM PROCESSING**

## **Section 3 Master Practice**

## **PAS: EMERGENCY ROOM PROCESSING**

### **Section 3. Master Practice**

#### **MASTER PRACTICE GUIDELINES**

This Master Practice enables the presenter to verify that you have successfully completed the objectives for this class.

The information you need to complete the Master Practice is supplied in the instructions, scenarios, and associated data cards. Data cards are found in Section 4 of the Student Guide.

You may use any reference materials available in the classroom to complete the Master Practice.

Device identifiers are site-specific, and will be provided by the presenter.

Unless otherwise directed by the presenter, please work alone to complete the Master Practice.

Notify the presenter when directed to do so in the Master Practice. This allows the presenter to verify that you have successfully completed an activity.

Information is only specified for those fields and prompts which require specific data entry. To advance past fields/prompts which are not specified, enter data you know to be correct, or press <Return>.

The components of the Master Practice should be completed in the order in which they are presented.

You have approximately 40 minutes to complete this Master Practice.

**NOTE TO PRESENTER:** Tell students whether they may write in their Student Guides while performing the practices/Master Practice. If the Student Guides must be used for another class session, you may not want students to write in their documents.

## **PAS: EMERGENCY ROOM PROCESSING**

**Scenario 1** - Check-in an unregistered patient to the ER and print the SF558.

**INSTRUCTIONS:** No additional instructions are required.

**Scenario:** *An ambulance has arrived with a frustrated young man. He was on his way to his wedding when he was involved in a minor traffic accident. The bridegroom is a serviceman on leave who is not registered at your facility. Fortunately, he was not seriously hurt, although he does have a stiff neck and a sore back and needs some pain medication.*

Access the New ER Patient Enter (NER) option on the Emergency Room Menu.

Select Clinic: **[clinic]** \*

Enter ER activity date: **<Return>** \*

**\*Note:** These prompts will only be displayed if you have just logged on to the system.

Register the patient.

Select Patient/Sponsor Name: **[patient/sponsor identifier]**  
Enter Sponsor FMP: **20**  
Enter Sponsor DOB: **7 APRIL 65**  
Enter Sponsor SSN: **[SSN]**  
Enter Sponsor/Patient Category: **A11**, then select USA AD Enlisted

File the data.

Override the DEERS ineligibility since the patient has been eligible for only three months: **3**  
Enter Patient Sex: **[patient sex]**  
Enter Patient Rank: **2LT**  
Enter Sponsor Station/Unit: **ENDIST KANSAS CITY**  
Enter O/P Rec Loc: **MEDICAL RECORDS FILE ROOM**  
Enter Patient wants to be an organ donor: **Y**

File the data.

Enter/Edit Allergy Information: **PENICILLINS**

Enter Allergy Comment: **SKIN RASH**

## **PAS: EMERGENCY ROOM PROCESSING**

### **Scenario 1** (continued)

File the data.

Continue: **<Return>**

Check-in the registered patient to the ER:

Enter Chief Complaint: **[see scenario]**  
Enter Method of Transit: **[see scenario]**  
Enter History Obtained From: **PATIENT**  
Enter Arrival Category: **[see scenario]**  
Enter Military Flying Status: **NO**

Notify the presenter when you have finished entering the above data. Allow the presenter to view your screen before you file the data.

File the data.

Print the SF558 worksheet:

Enter at Device: **[device]**

Notify the presenter when you have generated Encounter Form SF558 for the specified patient. Allow the presenter to view the encounter form before you continue.

The Emergency Room Menu displays.

## **PAS: EMERGENCY ROOM PROCESSING**

**Scenario 2** - Check-out a patient from the Emergency Room.

**INSTRUCTIONS:** No additional instructions are required.

**Scenario:** *The provider treating the patient in Scenario 1 has pronounced the patient well enough to be released. The patient will be ready to check-out of the ER in 15 minutes with a referral to the Orthopedic Clinic for tomorrow.*

Access the Check-Out & Patient Instructions (CER) option on the Emergency Room Menu.

Complete the CER screens:

Enter Patient Identifier: **[patient identifier]**  
Verify Provider: **<Return>**  
Enter Date/Time Seen by the Provider: **NOW**  
Enter the Date/Time of Release: **T@(now+15minutes)**  
Enter Outpatient Disposition: **HOME**  
Enter Referred To: **AORTHO** (Orthopedic Clinic)  
Enter Priority: **ROUTINE**  
Enter Release Condition: **IMPROVED**

Notify the presenter when you have finished entering data. Allow your presenter to view your screen before you file the data.

File the data.

Do not generate the SF558 worksheet.

Remain at the Emergency Room Menu.

## **PAS: EMERGENCY ROOM PROCESSING**

**Scenario 3** - Update a patient's Emergency Room encounter information.

**INSTRUCTIONS:** No additional instructions are required.

**Scenario:** *After the patient (from Scenarios 1 and 2) is discharged, you need to update his encounter information to reflect the following:*

- *The patient will not return to duty until seven days from today.*
- *Patient instructions include no lifting or bending until seen by Orthopedic Clinic provider.*
- *Change the next of kin to his new wife.*
- *The patient diagnosis is lower back strain.*

Access the Full ER Encounter (FER) option on the Emergency Room Menu.

Enter ER Patient Name: **[patient identifier]**

Enter the following information on the CER screen:

Enter the Modified Duty Until: **[see scenario]**

Enter Patient Instructions: **[see scenario]**

Notify the presenter when you are finished entering data. Allow the presenter to view your screen before you continue.

File the data.

Do not generate Encounter Form SF558 worksheet

Update appointment history and encounter (UER) data:

Enter next of kin: **[next of kin]**

Notify the presenter when you are finished entering data. Allow the presenter to view your screen before you continue.

File the data.

Enter problem, procedure, and diagnosis (PER) data:

Select Diagnosis (Free Text): **[see scenario]**

## **PAS: EMERGENCY ROOM PROCESSING**

### **Scenario 3** (continued)

Notify the presenter when you are finished entering data. Allow the presenter to view your screen before you continue.

File the data.

The Emergency Room Menu displays.

## **PAS: EMERGENCY ROOM PROCESSING**

**Scenario 4** - View past and future appointments for a specified patient and family member.

**INSTRUCTIONS:** No additional instructions are required.

**Scenario:** *A patient and oldest child have arrived needing urgent care. They are registered with your facility but cannot remember their provider's name. To save time, you look up the patient's and oldest child's past and future appointments to learn the identity of their provider.*

**Note:** Patients may or may not have *BOTH* past and future appointment history. However, patients will have at least past *OR* future appointment history.

Access the View Patient Appointment History (VER) option on the Emergency Room Menu.

Display past appointments for the patient:

Enter Patient Name: **[first family member]**  
Select the Past Appointments option.  
Enter at Device: **HOME**

Notify the presenter when you have the patient's appointment history on the screen. Inform the presenter of the name of the provider for the first appointment listed for this patient. Allow the presenter to view your screen before continuing.

Select to display or print past appointment history of another family member:

Select Family Member: **[second family member]**  
Select the Past Appointments option.  
Enter at Device: **HOME**

Notify the presenter when you have the patient's appointment history on the screen. Inform the presenter of the name of the provider for the first appointment listed for this patient. Allow the presenter to view your screen before continuing.

Select to display or print future appointments of another family member:

Enter Patient Name: **[first family member]**  
Select the Future Appointments option.  
Enter at Device: **HOME**

## **PAS: EMERGENCY ROOM PROCESSING**

### **Scenario 4** (continued)

Notify the presenter when you have the patient's appointment history on the screen. Inform the presenter of the name of the provider for the first appointment listed for this patient. Allow the presenter to view your screen before continuing.

Select to display or print future appointments of another family member:

Enter Patient Name: **[second family member]**

Select the Future Appointments option.

Enter at Device: **HOME**

Notify the presenter when you have the patient's appointment history on the screen. Inform the presenter of the name of the provider for the first appointment listed for this patient. Allow the presenter to view your screen before continuing.

Exit the option.

Return to the PAS System Menu.

Be sure to log off the training software when you finish with this Master Practice.

## **PAS: EMERGENCY ROOM PROCESSING**

### **Master Practice Evaluation Criteria**

**Scenario 1** - Check-in an unregistered patient to the ER and print the SF558.

**Direct** the students to check-in an unregistered patient to the ER and print the SF558 based on the information presented in the scenario and their data cards.

The students must use the New ER Patient Enter (NER) option to check-in the bridegroom as an unregistered patient. The students will notify you when they have completed registering the patient.

**Verify** that the students have registered the patient using the data contained in the scenario and their data cards.

The students will notify you again when they have finished entering the following patient check-in information:

- Chief Complaint: **BACK AND NECK PAIN**
- Method of Transit: **AMBULANCE**
- History Obtained From: **PATIENT**
- Arrival Category: **URGENT**

**Verify** that each student has entered the above data correctly by reviewing the NER and NER -- Continuation screens displayed at each student's terminal.

The students then must generate the SF558 on the classroom printer. You must identify the classroom printer device name to all students.

The students will notify you after they have generated the SF558 for the patient. Review the SF558 Encounter Form to verify that the data assigned to that student was entered correctly and that the student knows how to generate the SF558.

**Direct** the students to perform Scenario 2 without notifying you when they have completed performing this scenario.

## **PAS: EMERGENCY ROOM PROCESSING**

### **Master Practice Evaluation Criteria**

#### **Scenario 2** - Check-out a patient from the Emergency Room.

The students must use the Check-Out & Patient Instructions (CER) option to individually check-out the patient. The students will notify you after they have entered the information listed for this scenario on their student data cards.

**Review** the CER screen and each student's data card to verify that the data assigned to that student was entered correctly.

Students can invent data or leave blank any field not specified in the scenario or their data cards.

Students will not generate the Encounter Form SF558 worksheet.

The students will notify you to verify their data entry from student data cards.

**Verify** their work and allow them to proceed to Scenario 3.

#### **Scenario 3** - Update a patient's ER encounter information.

The student must use the Full ER Encounter (FER) option to complete the requirements of this scenario. The students will notify you at three different stages with entry and display of the following data from the scenario:

First: CER screen -  
Modified Duty Until: **T+7**

Second: Patient Instructions: **[to include no lifting or bending until seen by an Orthopedic Clinic provider]**

Third: Update Appointment History and Encounter (UER) Data --  
Continuation screen - Next of Kin: **[wife's name]** (as identified on the student data cards).

Fourth: Problem, Procedure, & Diagnosis (PER) screen - Diagnosis (Free Text): **LOWER BACK STRAIN**

**Review** the above screens to verify that the data assigned to that student was entered correctly.

**Direct** the students to go on to Scenario 4 without notifying you when they have completed this task.

## **PAS: EMERGENCY ROOM PROCESSING**

### **Master Practice Evaluation Criteria**

**Scenario 4** - View past and future appointments for a specified patient and family member.

The students must use the View Patient Appointment History (VER) option to complete the requirements of this scenario.

The students will notify you at four different stages with display of the following data from the screen:

First: The students will notify you when they have displayed the past appointment history for the patient. Ask the students to inform you of the identity of the patient's provider which is read from the first appointment on the list.

Second: The students will notify you when they have displayed the past appointment history for the family member. Ask the students to inform you of the identity of the patient's provider which is read from the first appointment on the list.

Third: The students will notify you when they have displayed future appointments for the patient. Ask the students to inform you of the identity of the patient's provider which is read from the first appointment on the list.

Fourth: The students will notify you when they have displayed future appointments for the family member. Ask the students to inform you of the identity of the patient's provider which is read from the first appointment on the list.

**Note:** Patients used in this Master Practice may or may not have both past and future appointment history. However, patients will have at least past or future appointment history.

**Verify** on students' screens that the correct patient, family member, and date are entered from the information contained in the scenario and the student data cards.

**Verify** that the students have logged off the training software at the completion of this Master Practice.

# **PAS: EMERGENCY ROOM PROCESSING**

## **Section 4 Data Cards**

## **PAS: EMERGENCY ROOM PROCESSING**

### **Section 4. Data Cards**

#### **Presenter**

Username: **TRAINING**  
Password:  
Area: **A**

Access: **PASERP**  
Verify: **PASERPV**

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#### **PRESENTER'S DEMONSTRATION DATA**

All required information is contained in the Class Outline.

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 1**

Username:	<b>TRAINING</b>	Access:	<b>PASERPA</b>
Password:		Verify:	<b>PASERPAV</b>
Area:	<b>A</b>		

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### **Practices:**

#### **Practice 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER01**  
Patient: **SHANKS,BARBARA B** (20/611-61-6201)  
Sponsor: **SHANKS,BARBARA B** (20/611-61-6201)  
Next of Kin: **SHANKS,BRITTANY**  
NOK-Phone: **(619)555-6789**

#### **Practice 2 - Register a Jane or John Doe patient.**

All required information is contained in the practice.

#### **Practice 3 - Check-out a patient from the Emergency Room.**

Patient: **SCOTT,BARBARA B** (20/600-60-6604)  
Provider: **CALHOUN**

#### **Practice 4 - Update a patient's Emergency Room encounter information.**

Clinic: **ER01**  
Patient: **SANDERS,BARBARA B** (20/600-60-6601)  
Provider: **CALHOUN**

#### **Practice 5 - View past and future appointments, and Wait List requests for a specified patient and family member.**

Clinic: **ER01**  
First Family Member: **SANDERS,BARBARA B** (20/600-60-6601)  
Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 1 (continued)**

#### **Practice 6 - Reprint the SF558.**

Patient: **SCOTT,BARBARA B** (20/600-60-6604)

#### **Practice 7 - Generate a partial JCAHO Control Register Log.**

Clinic: **ER01**

#### **Practice 8 - Disposition specified patients from the Emergency Room using the Disposition Processing option.**

<u>Patients</u>	<u>Provider</u>	<u>Date/Time Seen</u>	<u>Date/Time Released</u>
<b>SHAW,ALLAN</b>	<b>CALHOUN</b>	<b>T@1100</b>	<b>T@1130</b>
<b>SHAW,BARBARA</b>	<b>CALHOUN</b>	<b>T@1130</b>	<b>T@1200</b>

### **Master Practice:**

#### **Scenario 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER01**

Patient: **STOUT,ALLAN A** (20/616-62-7203)

Sponsor: **STOUT,ALLAN A** (20/616-62-7203)

Patient Sex: **MALE**

#### **Scenario 2 - Check-out a patient from the Emergency Room.**

All required information is contained in the practice.

#### **Scenario 3 - Update a patient's Emergency Room encounter information.**

Next of Kin: **STOUT,ALICE**

#### **Scenario 4 - View past and future appointments, and Wait List requests for a specified patient and family member.**

First Family Member: **SAWYER,ANN** (30/600-60-6502)

Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 2**

Username:	<b>TRAINING</b>	Access:	<b>PASERPB</b>
Password:		Verify:	<b>PASERPBV</b>
Area:	<b>A</b>		

---

### **Practices:**

#### **Practice 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER2**  
Patient: **SHANKS,CHARLOTTE C** (20/611-61-6301)  
Sponsor: **SHANKS,CHARLOTTE C** (20/611-61-6301)  
Next of Kin: **SHANKS,CHARLES**  
NOK-Phone: **(619)555-6790**

#### **Practice 2 - Register a Jane or John Doe patient.**

All required information is contained in the practice.

#### **Practice 3 - Check-out a patient from the Emergency Room.**

Patient: **SCOTT,CHARLES C** (20/600-60-6704)  
Provider: **CALLAWAY**

#### **Practice 4 - Update a patient's Emergency Room encounter information.**

Clinic: **ER2**  
Patient: **SANDERS,CHARLES C** (20/600-60-6701)  
Provider: **CALLAWAY**

#### **Practice 5 - View past and future appointments, and Wait List requests for a specified patient and family member.**

Clinic: **ER2**  
First Family Member: **SANDERS,CHARLES C** (20/600-60-6701)  
Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 2 (continued)**

#### **Practice 6 - Reprint the SF558.**

Patient: **SCOTT,CHARLES C** (20/600-60-6704)

#### **Practice 7 - Generate a partial JCAHO Control Register Log.**

Clinic: **ER2**

#### **Practice 8 - Disposition specified patients from the Emergency Room using the Disposition Processing option.**

<u>Patients</u>	<u>Provider</u>	<u>Date/Time Seen</u>	<u>Date/Time Released</u>
<b>SHAW,ALLAN</b>	<b>CALLAWAY</b>	<b>T@1100</b>	<b>T@1130</b>
<b>SHAW,BARBARA</b>	<b>CALLAWAY</b>	<b>T@1130</b>	<b>T@1200</b>

### **Master Practice:**

#### **Scenario 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER2**

Patient: **STOUT,BASIL B** (20/616-62-7303)

Sponsor: **STOUT,BASIL B** (20/616-62-7303)

Patient Sex: **MALE**

#### **Scenario 2 - Check-out a patient from the Emergency Room.**

All required information is contained in the practice.

#### **Scenario 3 - Update a patient's Emergency Room encounter information.**

Next of Kin: **STOUT,BETH**

#### **Scenario 4 - View past and future appointments, and Wait List requests for a specified patient and family member.**

First Family Member: **SAWYER,BARBARA B** (20/600-60-6602)

Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 3**

Username: **TRAINING**  
Password:  
Area: **A**

Access: **PASERPC**  
Verify: **PASERPCV**

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### **Practices:**

#### **Practice 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER3**  
Patient: **SHANKS,DORIS D** (20/611-61-6401)  
Sponsor: **SHANKS,DORIS D** (20/611-61-6401)  
Next of Kin: **SHANKS,DONALD**  
NOK-Phone: **(619)555-6791**

#### **Practice 2 - Register a Jane or John Doe patient.**

All required information is contained in the practice.

#### **Practice 3 - Check-out a patient from the Emergency Room.**

Patient: **SCOTT,DONNA D** (20/600-60-6804)  
Provider: **CALLAWAY**

#### **Practice 4 - Update a patient's Emergency Room encounter information.**

Clinic: **ER3**  
Patient: **SANDERS,DONNA D** (20/600-60-6801)  
Provider: **CALLAWAY**

#### **Practice 5 - View past and future appointments, and Wait List requests for a specified patient and family member.**

Clinic: **ER3**  
First Family Member: **SANDERS,DONNA D** (20/600-60-6801)  
Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 3 (continued)**

#### **Practice 6 - Reprint the SF558.**

Patient: **SCOTT,DONNA D** (20/600-60-6804)

#### **Practice 7 - Generate a partial JCAHO Control Register Log.**

Clinic: **ER3**

#### **Practice 8 - Disposition specified patients from the Emergency Room using the Disposition Processing option.**

<u>Patients</u>	<u>Provider</u>	<u>Date/Time Seen</u>	<u>Date/Time Released</u>
<b>SHAW,ALLAN</b>	<b>CALLAWAY</b>	<b>T@1100</b>	<b>T@1130</b>
<b>SHAW,BARBARA</b>	<b>CALLAWAY</b>	<b>T@1130</b>	<b>T@1200</b>

### **Master Practice:**

#### **Scenario 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER3**

Patient: **STOUT,CYRUS C** (20/616-62-7403)

Sponsor: **STOUT,CYRUS C** (20/616-62-7403)

Patient Sex: **MALE**

#### **Scenario 2 - Check-out a patient from the Emergency Room.**

All required information is contained in the practice.

#### **Scenario 3 - Update a patient's Emergency Room encounter information.**

Next of Kin: **STOUT,CHERYL**

#### **Scenario 4 - View past and future appointments, and Wait List requests for a specified patient and family member.**

First Family Member: **SAWYER,CATHY** (30/600-60-6702)

Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 4**

Username:	<b>TRAINING</b>	Access:	<b>PASERPD</b>
Password:		Verify:	<b>PASERPDV</b>
Area:	<b>A</b>		

---

### **Practices:**

#### **Practice 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER4**  
Patient: **SHANKS,ELLEN E** (20/611-61-6501)  
Sponsor: **SHANKS,ELLEN E** (20/611-61-6501)  
Next of Kin: **SHANKS,ELWOOD**  
NOK-Phone: **(619)555-6792**

#### **Practice 2 - Register a Jane or John Doe patient.**

All required information is contained in the practice.

#### **Practice 3 - Check-out a patient from the Emergency Room.**

Patient: **SCOTT,EARL E** (20/600-60-6904)  
Provider: **CAMERON**

#### **Practice 4 - Update a patient's Emergency Room encounter information.**

Clinic: **ER4**  
Patient: **SANDERS,EARL E** (20/600-60-6901)  
Provider: **CAMERON**

#### **Practice 5 - View past and future appointments, and Wait List requests for a specified patient and family member.**

Clinic: **ER4**  
First Family Member: **SANDERS,EARL E** (20/600-60-6901)  
Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 4 (continued)**

#### **Practice 6 - Reprint the SF558.**

Patient: **SCOTT,EARL E** (20/600-60-6904)

#### **Practice 7 - Generate a partial JCAHO Control Register Log.**

Clinic: **ER4**

#### **Practice 8 - Disposition specified patients from the Emergency Room using the Disposition Processing option.**

<u>Patients</u>	<u>Provider</u>	<u>Date/Time Seen</u>	<u>Date/Time Released</u>
<b>SHAW,ALLAN</b>	<b>CAMERON</b>	<b>T@1100</b>	<b>T@1130</b>
<b>SHAW,BARBARA</b>	<b>CAMERON</b>	<b>T@1130</b>	<b>T@1200</b>

### **Master Practice:**

#### **Scenario 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER4**

Patient: **STOUT,DOUGLASS D** (20/616-62-7503)

Sponsor: **STOUT,DOUGLASS D** (20/616-62-7503)

Patient Sex: **MALE**

#### **Scenario 2 - Check-out a patient from the Emergency Room.**

All required information is contained in the practice.

#### **Scenario 3 - Update a patient's Emergency Room encounter information.**

Next of Kin: **STOUT,DAPHNE**

#### **Scenario 4 - View past and future appointments, and Wait List requests for a specified patient and family member.**

First Family Member: **SAWYER,DAVID** (30/600-60-6802)

Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 5**

Username:	<b>TRAINING</b>	Access:	<b>PASERPE</b>
Password:		Verify:	<b>PASERPEV</b>
Area:	<b>A</b>		

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### **Practices:**

#### **Practice 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER5**  
Patient: **SHANKS,FRANCES F** (20/611-61-6601)  
Sponsor: **SHANKS,FRANCES F** (20/611-61-6601)  
Next of Kin: **SHANKS,FRANKLIN**  
NOK-Phone: **(619)555-6793**

#### **Practice 2 - Register a Jane or John Doe patient.**

All required information is contained in the practice.

#### **Practice 3 - Check-out a patient from the Emergency Room.**

Patient: **SCOTT,FLORENCE F** (20/600-60-7004)  
Provider: **CANNON**

#### **Practice 4 - Update a patient's Emergency Room encounter information.**

Clinic: **ER5**  
Patient: **SANDERS,FLORENCE F** (20/600-60-7001)  
Provider: **CANNON**

#### **Practice 5 - View past and future appointments, and Wait List requests for a specified patient and family member.**

Clinic: **ER5**  
First Family Member: **SANDERS,FLORENCE F** (20/600-60-7001)  
Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 5 (continued)**

#### **Practice 6 - Reprint the SF558.**

Patient: **SCOTT,FLORENCE F** (20/600-60-7004)

#### **Practice 7 - Generate a partial JCAHO Control Register Log.**

Clinic: **ER5**

#### **Practice 8 - Disposition specified patients from the Emergency Room using the Disposition Processing option.**

<u>Patients</u>	<u>Provider</u>	<u>Date/Time Seen</u>	<u>Date/Time Released</u>
<b>SHAW,ALLAN</b>	<b>CANNON</b>	<b>T@1100</b>	<b>T@1130</b>
<b>SHAW,BARBARA</b>	<b>CANNON</b>	<b>T@1130</b>	<b>T@1200</b>

### **Master Practice:**

#### **Scenario 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER5**

Patient: **STOUT,ERROL E** (20/616-62-7603)

Sponsor: **STOUT,ERROL E** (20/616-62-7603)

Patient Sex: **MALE**

#### **Scenario 2 - Check-out a patient from the Emergency Room.**

All required information is contained in the practice.

#### **Scenario 3 - Update a patient's Emergency Room encounter information.**

Next of Kin: **STOUT,ELEANOR**

#### **Scenario 4 - View past and future appointments, and Wait List requests for a specified patient and family member.**

First Family Member: **SAWYER,EARL E** (20/600-60-6902)

Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 6**

Username: **TRAINING**  
Password:  
Area: **A**

Access: **PASERPF**  
Verify: **PASERPFV**

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### **Practices:**

#### **Practice 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER6**  
Patient: **SHANKS,GERALDINE G** (20/611-61-6701)  
Sponsor: **SHANKS,GERALDINE G** (20/611-61-6701)  
Next of Kin: **SHANKS,GARY**  
NOK-Phone: **(619)555-6794**

#### **Practice 2 - Register a Jane or John Doe patient.**

All required information is contained in the practice.

#### **Practice 3 - Check-out a patient from the Emergency Room.**

Patient: **SCOTT,GEORGE G** (20/600-60-7104)  
Provider: **CARPENTER**

#### **Practice 4 - Update a patient's Emergency Room encounter information.**

Clinic: **ER6**  
Patient: **SANDERS,GEORGE G** (20/600-60-7101)  
Provider: **CARPENTER**

#### **Practice 5 - View past and future appointments, and Wait List requests for a specified patient and family member.**

Clinic: **ER6**  
First Family Member: **SANDERS,GEORGE G** (20/600-60-7101)  
Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 6 (continued)**

#### **Practice 6 - Reprint the SF558.**

Patient: **SCOTT,GEORGE G** (20/600-60-7104)

#### **Practice 7 - Generate a partial JCAHO Control Register Log.**

Clinic: **ER6**

#### **Practice 8 - Disposition specified patients from the Emergency Room using the Disposition Processing option.**

<u>Patients</u>	<u>Provider</u>	<u>Date/Time Seen</u>	<u>Date/Time Released</u>
<b>SHAW,ALLAN</b>	<b>CARPENTER</b>	<b>T@1100</b>	<b>T@1130</b>
<b>SHAW,BARBARA</b>	<b>CARPENTER</b>	<b>T@1130</b>	<b>T@1200</b>

### **Master Practice:**

#### **Scenario 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER6**

Patient: **STOUT,FREDERICK F** (20/616-62-7703)

Sponsor: **STOUT,FREDERICK F** (20/616-62-7703)

Patient Sex: **MALE**

#### **Scenario 2 - Check-out a patient from the Emergency Room.**

All required information is contained in the practice.

#### **Scenario 3 - Update a patient's Emergency Room encounter information.**

Next of Kin: **STOUT,FAWN**

#### **Scenario 4 - View past and future appointments, and Wait List requests for a specified patient and family member.**

First Family Member: **SAWYER,FLORENCE F** (20/600-60-7002)

Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 7**

Username:	<b>TRAINING</b>	Access:	<b>PASERPG</b>
Password:		Verify:	<b>PASERPGV</b>
Area:	<b>A</b>		

---

### **Practices:**

#### **Practice 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER7**  
Patient: **SHANKS,HELEN H** (20/611-61-6801)  
Sponsor: **SHANKS,HELEN H** (20/611-61-6801)  
Next of Kin: **SHANKS,HOWARD**  
NOK-Phone: **(619)555-6795**

#### **Practice 2 - Register a Jane or John Doe patient.**

All required information is contained in the practice.

#### **Practice 3 - Check-out a patient from the Emergency Room.**

Patient: **SCOTT,HOLLEY H** (20/600-60-7204)  
Provider: **CARSON**

#### **Practice 4 - Update a patient's Emergency Room encounter information.**

Clinic: **ER7**  
Patient: **SANDERS,HOLLEY H** (20/600-60-7201)  
Provider: **CARSON**

#### **Practice 5 - View past and future appointments, and Wait List requests for a specified patient and family member.**

Clinic: **ER7**  
First Family Member: **SANDERS,HOLLEY H** (20/600-60-7201)  
Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 7 (continued)**

#### **Practice 6 - Reprint the SF558.**

Patient: **SCOTT,HOLLEY H** (20/600-60-7204)

#### **Practice 7 - Generate a partial JCAHO Control Register Log.**

Clinic: **ER7**

#### **Practice 8 - Disposition specified patients from the Emergency Room using the Disposition Processing option.**

<u>Patients</u>	<u>Provider</u>	<u>Date/Time Seen</u>	<u>Date/Time Released</u>
<b>SHAW,ALLAN</b>	<b>CARSON</b>	<b>T@1100</b>	<b>T@1130</b>
<b>SHAW,BARBARA</b>	<b>CARSON</b>	<b>T@1130</b>	<b>T@1200</b>

### **Master Practice:**

#### **Scenario 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER7**

Patient: **STOUT,GEORGE G** (20/616-62-7803)

Sponsor: **STOUT,GEORGE G** (20/616-62-7803)

Patient Sex: **MALE**

#### **Scenario 2 - Check-out a patient from the Emergency Room.**

All required information is contained in the practice.

#### **Scenario 3 - Update a patient's Emergency Room encounter information.**

Next of Kin: **STOUT,GERTRUDE**

#### **Scenario 4 - View past and future appointments, and Wait List requests for a specified patient and family member.**

First Family Member: **SAWYER,GEORGE G** (20/600-60-7102)

Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 8**

Username:	<b>TRAINING</b>	Access:	<b>PASERPH</b>
Password:		Verify:	<b>PASERPHV</b>
Area:	<b>A</b>		

---

### **Practices:**

#### **Practice 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER8**  
Patient: **SHANKS,INA** (20/611-61-6901)  
Sponsor: **SHANKS,INA** (20/611-61-6901)  
Next of Kin: **SHANKS,IRA**  
NOK-Phone: **(619)555-6796**

#### **Practice 2 - Register a Jane or John Doe patient.**

All required information is contained in the practice.

#### **Practice 3 - Check-out a patient from the Emergency Room.**

Patient: **SCOTT,IAN I** (20/600-60-7304)  
Provider: **CHRISTOPHER**

#### **Practice 4 - Update a patient's Emergency Room encounter information.**

Clinic: **ER8**  
Patient: **SANDERS,IAN I** (20/600-60-7301)  
Provider: **CHRISTOPHER**

#### **Practice 5 - View past and future appointments, and Wait List requests for a specified patient and family member.**

Clinic: **ER8**  
First Family Member: **SANDERS,IAN I** (20/600-60-7301)  
Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 8 (continued)**

#### **Practice 6 - Reprint the SF558.**

Patient: **SCOTT, IAN I** (20/600-60-7304)

#### **Practice 7 - Generate a partial JCAHO Control Register Log.**

Clinic: **ER8**

#### **Practice 8 - Disposition specified patients from the Emergency Room using the Disposition Processing option.**

<u>Patients</u>	<u>Provider</u>	<u>Date/Time Seen</u>	<u>Date/Time Released</u>
<b>SHAW, ALLAN</b>	<b>CHRISTOPHER</b>	<b>T@1100</b>	<b>T@1130</b>
<b>SHAW, BARBARA</b>	<b>CHRISTOPHER</b>	<b>T@1130</b>	<b>T@1200</b>

### **Master Practice:**

#### **Scenario 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER8**

Patient: **STOUT, HORACE H** (20/616-62-7903)

Sponsor: **STOUT, HORACE H** (20/616-62-7903)

Patient Sex: **MALE**

#### **Scenario 2 - Check-out a patient from the Emergency Room.**

All required information is contained in the practice.

#### **Scenario 3 - Update a patient's Emergency Room encounter information.**

Next of Kin: **STOUT, HARRIET**

#### **Scenario 4 - View past and future appointments, and Wait List requests for a specified patient and family member.**

First Family Member: **SAWYER, HAROLD** (30/600-60-7202)

Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 9**

Username: **TRAINING**  
Password:  
Area: **A**

Access: **PASERPI**  
Verify: **PASERPIV**

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### **Practices:**

#### **Practice 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER9**  
Patient: **SHANKS,JANE J** (20/611-61-6111)  
Sponsor: **SHANKS,JANE J** (20/611-61-6111)  
Next of Kin: **SHANKS,JOHN**  
NOK-Phone: **(619)555-6797**

#### **Practice 2 - Register a Jane or John Doe patient.**

All required information is contained in the practice.

#### **Practice 3 - Check-out a patient from the Emergency Room.**

Patient: **SCOTT,JACKIE J** (20/600-60-7404)  
Provider: **COMSTOCK**

#### **Practice 4 - Update a patient's Emergency Room encounter information.**

Clinic: **ER9**  
Patient: **SANDERS,JACKIE J** (20/600-60-7401)  
Provider: **COMSTOCK**

#### **Practice 5 - View past and future appointments, and Wait List requests for a specified patient and family member.**

Clinic: **ER9**  
First Family Member: **SANDERS,JACKIE J** (20/600-60-7401)  
Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 9 (continued)**

#### **Practice 6 - Reprint the SF558.**

Patient: **SCOTT,JACKIE J** (20/600-60-7404)

#### **Practice 7 - Generate a partial JCAHO Control Register Log.**

Clinic: **ER9**

#### **Practice 8 - Disposition specified patients from the Emergency Room using the Disposition Processing option.**

<u>Patients</u>	<u>Provider</u>	<u>Date/Time Seen</u>	<u>Date/Time Released</u>
<b>SHAW,ALLAN</b>	<b>COMSTOCK</b>	<b>T@1100</b>	<b>T@1130</b>
<b>SHAW,BARBARA</b>	<b>COMSTOCK</b>	<b>T@1130</b>	<b>T@1200</b>

### **Master Practice:**

#### **Scenario 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER9**

Patient: **STOUT,LAWRENCE L** (20/616-62-7113)

Sponsor: **STOUT,LAWRENCE L** (20/616-62-7113)

Patient Sex: **MALE**

#### **Scenario 2 - Check-out a patient from the Emergency Room.**

All required information is contained in the practice.

#### **Scenario 3 - Update a patient's Emergency Room encounter information.**

Next of Kin: **STOUT,LORRAINE**

#### **Scenario 4 - View past and future appointments, and Wait List requests for a specified patient and family member.**

First Family Member: **SANDERS,BARBARA B** (20/600-60-6601)

Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 10**

Username: **TRAINING**  
Password:  
Area: **A**

Access: **PASERPJ**  
Verify: **PASERPJV**

---

### **Practices:**

#### **Practice 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER10**  
Patient: **SHANKS,KARLA K** (20/611-61-6121)  
Sponsor: **SHANKS,KARLA K** (20/611-61-6121)  
Next of Kin: **SHANKS,KEVIN**  
NOK-Phone: **(619)555-6798**

#### **Practice 2 - Register a Jane or John Doe patient.**

All required information is contained in the practice.

#### **Practice 3 - Check-out a patient from the Emergency Room.**

Patient: **SCOTT,KENNETH K** (20/600-60-7504)  
Provider: **COXAL**

#### **Practice 4 - Update a patient's Emergency Room encounter information.**

Clinic: **ER10**  
Patient: **SANDERS,KENNETH K** (20/600-60-7501)  
Provider: **COXAL**

#### **Practice 5 - View past and future appointments, and Wait List requests for a specified patient and family member.**

Clinic: **ER10**  
First Family Member: **SANDERS,KENNETH K** (20/600-60-7501)  
Second Family Member: **01** (oldest child)

## **PAS: EMERGENCY ROOM PROCESSING**

### **Student 10 (continued)**

#### **Practice 6 - Reprint the SF558.**

Patient: **SCOTT,KENNETH K** (20/600-60-7504)

#### **Practice 7 - Generate a partial JCAHO Control Register Log.**

Clinic: **ER 10**

#### **Practice 8 - Disposition specified patients from the Emergency Room using the Disposition Processing option.**

<u>Patients</u>	<u>Provider</u>	<u>Date/Time Seen</u>	<u>Date/Time Released</u>
<b>SHAW,ALLAN</b>	<b>COXAL</b>	<b>T@1100</b>	<b>T@1130</b>
<b>SHAW,BARBARA</b>	<b>COXAL</b>	<b>T@1130</b>	<b>T@1200</b>

### **Master Practice:**

#### **Scenario 1 - Check-in an unregistered patient to the Emergency Room and print the SF558.**

Clinic: **ER10**

Patient: **STOUT,MICHAEL M** (20/616-62-7123)

Sponsor: **STOUT,MICHAEL M** (20/616-62-7123)

Patient Sex: **MALE**

#### **Scenario 2 - Check-out a patient from the Emergency Room.**

All required information is contained in the practice.

#### **Scenario 3 - Update a patient's Emergency Room encounter information.**

Next of Kin: **STOUT,MICHELE**

#### **Scenario 4 - View past and future appointments, and Wait List requests for a specified patient and family member.**

First Family Member: **SANDERS,CHARLES C** (20/600-60-6701)

Second Family Member: **01** (oldest child)

# **PAS: EMERGENCY ROOM PROCESSING**

## **Section 5 Reference Materials**

**PAS: EMERGENCY ROOM PROCESSING**  
**Section 5. Reference Materials**

**Index**

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DISPLAY PATIENT APPOINTMENTS .....	5-4
END-OF-DAY PROCESSING .....	5-6

## PATIENT LOOKUP

**Note:** The following procedures should be used for patient lookup and entry within CHCS. These procedures **MUST** also be followed prior to entering a new patient into CHCS to minimize the chance of duplicate patient entry.

!! **IMPORTANT** !!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

It is critical to identify patients in CHCS correctly. Small differences in the entry of a patient name can create a duplicate patient entry. **PLEASE BE CAREFUL.** Adding a duplicate patient to the database can have a significant impact on patient safety.

To register a new patient, you must have been assigned the ampersand (&) FileMan access code. If necessary, you can edit an existing patient registration without the code.

Sample patient information: JOHNSON,ROGER M 20/213-38-2739

↑	↑	↑	↑	↑
Last	First	Initial	FMP	SSN
Name	Name			

The following method of patient lookup and entry is strongly recommended, and must be followed **PRIOR** to registering a patient:

This is the preferred method of patient lookup.

**FIRST STEP:** Enter the first letter of the patient's last name and last four digits of the sponsor's Social Security number.  
(i.e., Select Patient: **J2739**)

Check the display closely. If the patient information matches, verify the selection. Go to the second step if a match is not found.

**SECOND STEP:** Enter the sponsor's full Social Security number.  
(i.e., Select Patient: **213382739**)

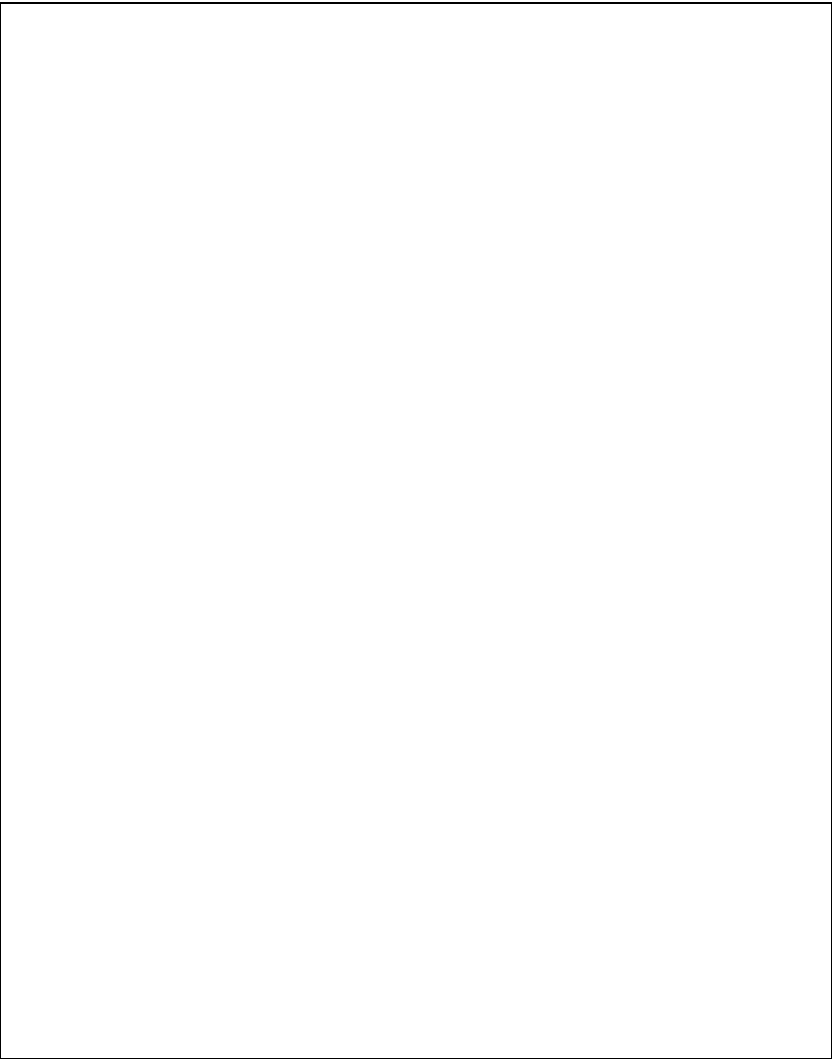
Check the display closely. If the patient information matches, verify the selection. Go to the third step if a match is not found.

**THIRD STEP:** Enter the patient's last name.  
(i.e., Select Patient: **JOHNSON**)

Check the display closely, look for the listing that matches the patient information you have. If there is no match, you may register the patient as a new patient using the following convention: LAST NAME,FIRST MI (no space between last and first name, a space between first name and initial, no period after initials, then press <Return>).

CHCS

PATIENT LOOKUP



**DISPLAY PATIENT APPOINTMENTS**

The Display Patient Appointments option allows you to display or print a patient's future or past appointments as well as those of other family members registered under the same Social Security number.

MENU PATH: PAS System Menu → Clerk Scheduling Menu → DPA

Select PATIENT NAME: SANDERS,ALLAN  
20/600-60-6501 16 Mar 1975 M AO3

OK? YES//

Select (F)uture, (P)ast, (W)ait List, (S)pecific Date, (Q)uit: F// S

Display from which Date: 15 Jun 2001  
Device: <Return>  
RIGHT MARGIN: 80// <Return>

**PAS**

**DISPLAY PATIENT APPOINTMENTS**

**DISPLAY PATIENT APPOINTMENTS (continued)**

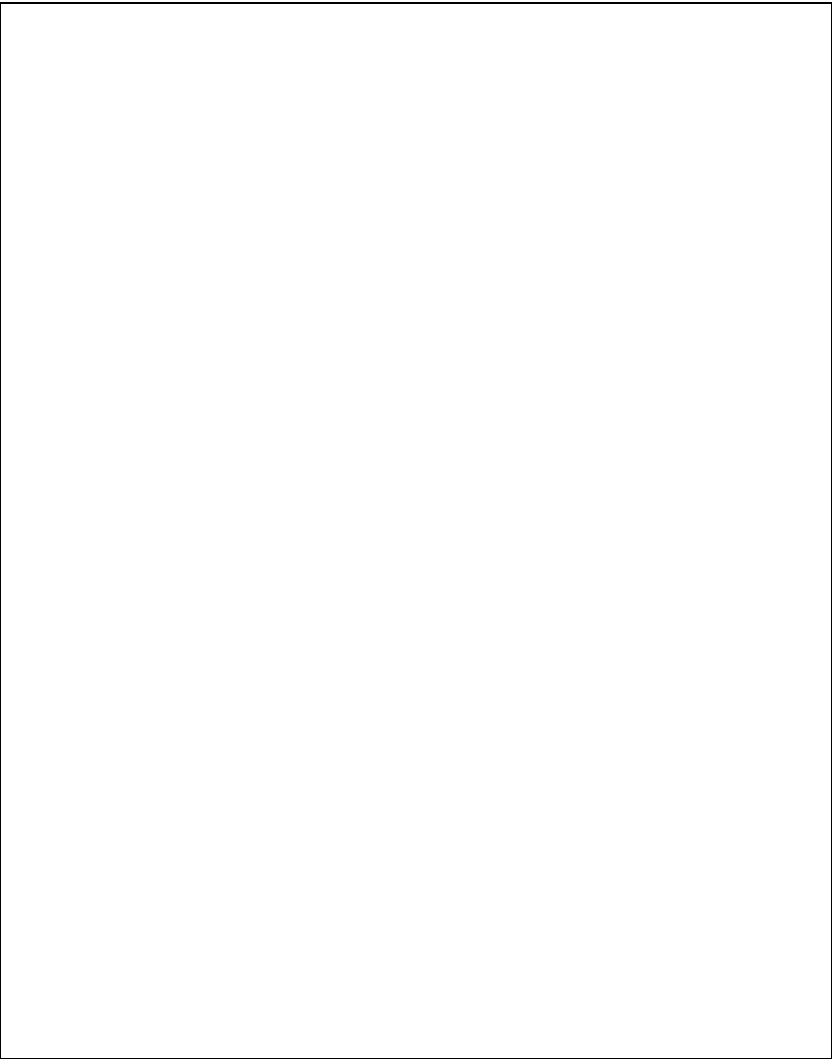
DISPLAY PATIENT APPOINTMENTS				
Personal Data - Privacy Act of 1974 (PL 93-579)				
History of Appts for SANDERS,ALLAN from: 15 Jun 2001				
CLINIC/DIV	PROVIDER	DATE/TIME	TYPE	STATUS
=====				
(Appointment data)				
WAIT LIST REQUESTS FOR SANDERS,ALLAN (FMP/SSN)				
CLINIC/DIV	TYPE58	PRI	DATE IN	TARGET DATE PROVIDER
=====				
(Wait List data)				
=====				
Press <Return> to continue				
Display/Print Appointment History of Other Family Member? No// <Return>				

**Notes:**

- Displaying a patient's appointment is a quick way to find out which provider saw a patient on a previous visit so that return visits can be scheduled with the same provider for continuity of care.
- DPA printouts may be given to patients to remind them of future appointments.
- DPA printouts also provide a listing of applicable instructions and appointment type messages.

- The Display Appointments display is divided into two sections:
  - Top section lists past and future appointments for the patient.
  - Bottom section lists the Wait List requests for the patient.
- Appointment status of Cancel indicates that the appointment was cancelled.
- Appointment status of Cancel(P) indicates that the appointment was cancelled by Patient.
- Appointment status of Cancel(F) indicates that the appointment was cancelled by Facility (Provider).
- Displaying patient appointments in the past will show appointments up to 360 days in the past

**PAS****DISPLAY PATIENT APPOINTMENTS**



**END-OF-DAY PROCESSING**

This option allows you to edit, modify, or update patient appointment history data including the status of daily appointments for each clinic and provider.

MENU PATH: PAS System Menu → Clerk Scheduling Menu → EOD

END-OF-DAY PROCESSING

Clinic:  
Provider:  
Time Range: 0001 t2001 to 21 Jun 2001  
Dates: 21 Jun 2001 to 21 Jun 2001

Place of Care is REQUIRED

Select (C)hange Search Criteria, or (Q)uit: C// <Return>

PAS

**END-OF-DAY PROCESSING**

**END-OF-DAY PROCESSING (continued)****END-OF-DAY PROCESSING**

Clinic: \_\_\_\_\_ Appt. Type: \_\_\_\_\_  
 Provider: \_\_\_\_\_  
 Time Range: 0001 to 2400  
 Dates: 21 Jun 2001 to 21 Jun 2001

- 
- \* Clinic
  - \* Provider
  - Time Range
  - Date Range
  - \* Data Elements
  - Delinquent Appointments Only
  - Default Search Criteria

---

Clinic is REQUIRED

SELECT to mark the Search Criteria to be changed

---

Select Clinic: CAST  
 Select Provider: CALHOUN,CRAIG

**END-OF-DAY PROCESSING**

Clinic: CAST CLINIC/DIVA Appt. Type: \_\_\_\_\_  
 Provider: CALHOUN,CRAIG  
 Time Range: 0001 to 2400  
 Dates: 21 Jun 2001 to 21 Jun 2001

- 
- \* Appointment Status
  - \* MEPRS Code
  - Provider
  - Secondary Provider
  - Outpatient Disposition
  - Provider's Comment
  - Clinic
  - Appointment Type
  - + Appointment Date/Time

---

Select DATA ELEMENTS to edit  
 Select (C)hange Search Criteria, (S)earch for Appts, (Q)uit: S// <Return>

**PAS****END-OF-DAY PROCESSING**

**END-OF-DAY PROCESSING (continued)****END-OF-DAY PROCESSING**

Clinic: CAST CLINIC/DIVA  
 Provider: CALHOUN,CRAIG  
 Time Range: 0001 to 2400  
 Dates: 21 Jun 2001 to 21 Jun 2001

```
=====
0900 SCHMIDT,BARBARA B 20/6603 RET CALHOUN,CR 21 Jun 2001 BEBA Pending
0930 SCOTT,OLIVER O    20/7904 RET CALHOUN,CR 21 Jun 2001 BEBA Pending
1011 SCOTT,OLIVER O    20/7904 RET CALHOUN,CR 21 Jun 2001 BEBA Tel-Con
1030 SCOTT,CHARLES C   20/6704 RET CALHOUN,CR 21 Jun 2001 BEBA Pending
1311 AMHOFF,ALLAN A    20/2345 WI          21 Jun 2001 BEBA Walk-In
=====
```

Select appointment(s) to process

**END-OF-DAY PROCESSING****PATIENT APPT DATA**

Personal Data - Privacy Act of 1974

Patient: SHAW,CHARLES C

FMP/SSN: 20/600-60-6705

```
-----
Appt Date/Time: 21 Jun 2001@0700      Appt Status: PENDING
Clinic:         CAST CLINIC           MEPRS:      BEBA
Provider:       CALHOUN,CRAIG M       Appt Type:  NEW
Secondary Provider:
Referred By:
Appt Comment:
Reason for Appt:
```

Checked-In:  
Request Svc:

Cancelled By:  
Date/Time Cancelled:

Help = HELP

Exit = F10

File/Exit = DO

INSERT OFF

```
-----
Appointment Status: PENDING// 4 (NO-SHOW)
Press <Return> to continue
```

File the data.

**PAS**

**END-OF-DAY PROCESSING**

**END-OF-DAY PROCESSING (continued)**

END-OF-DAY PROCESSING	PATIENT APPT DATA
Personal Data - Privacy Act of 1974	
Patient: SHAW,CHARLES C	FMP/SSN: 20/600-60-6705

Outpatient Disposition:  
Modified Duty Until:  
Referred To:  
Admitted To:  
Provider's Comment:

Help = HELP      Exit = F10      File/Exit = DO      INSERT OFF

END-OF-DAY PROCESSING  
Place of Care: CAST CLINIC/DIVA  
Provider: CALHOUN,CRAIG M  
Time Range: 0001 to 2400  
Dates: 21 Jun 2001 to 21 Jun 2001

Select: (C)hange Search Criteria, (S)earch for Appointments,  
(P)rint EOD Reports, or (Q)uit: P// <Return>

**EOD REPORTS**

Place of Care: CAST CLINIC/DIVA  
Provider: CALHOUN,CRAIG M  
Time Range: 0001 to 2400  
Dates: 21 Jun 2001 to 21 Jun 2001

-----There are missing providers and/or pendings appointments-----  
Select (D)elinquent EOD Report, (E)nd-of-Day Processing Report, or (Q)uit: D// E

**EOD REPORTS**

Place of Care: CAST CLINIC/DIVA  
Provider: CALHOUN,CRAIG M  
Time Range: 0001 to 2400  
Dates: 21 Jun 2001 to 21 Jun 2001

-----There are missing providers and/or pendings appointments-----  
Enter DEVICE: [device identifier]      RIGHT MARGIN: 80// <Return>

**PAS****END-OF-DAY PROCESSING**

**END-OF-DAY PROCESSING (continued)**

TIME	PATIENT NAME	FMP/SSN	TYPE	PROVIDER	DATE	MEPRS STATUS
0900	SCHMIDT,BARBARA B	20/6603	RET	CALHOUN,CR	21 Jun 2001	BEBA No-Show
0930	SCOTT,OLIVER O	20/7904	RET	CALHOUN,CR	21 Jun 2001	BEBA Pending
1011	SCOTT,OLIVER O	20/7904	RET	CALHOUN,CR	21 Jun 2001	BEBA Tel-Con
1030	SCOTT,CHARLES C	20/6704	RET	CALHOUN,CR	21 Jun 2001	BEBA Pending
1311	AMHOFF,ALLAN A	20/2345	WI		21 Jun 2001	BEBA Walk-In

**\*\*Daily Clinic Appointment Status Summary with COUNT Appt. Types\*\***

Provider	Kpt	WI	SC	TC	Can	NS	Adm	LWOBS	O-S	Total
SEYMOUR,RO	0	0	0	0	0	1	0	0	0	0
<b>Total</b>	0	0	0	0	0	1	0	0	0	1

**\*\*Daily Clinic Appointment Status Summary with NONCOUNT Appt. Types\*\***

Provider	Kpt	WI	SC	TC	Can	NS	Adm	LWOBS	O-S	Total
SEYMOUR,RO	0	0	0	1	0	0	0	0	0	0
<b>Total</b>	0	0	0	1	0	0	0	0	0	1

**Notes:**

- Place of Care is a required field.

- To save yourself time in your search you may elect to only use the editing criterion 'Data Elements.' With this selection you select only those fields you need to change. For example, you may decide to change appointment status and Provider.
- There are 14 data elements that you can identify by either a number code or by name. Double question marks (??) at the prompt allows you to see these available elements.
- All end-of-day processing must be completed within seven days of the appointment. After seven days, only supervisory personnel with the SDCL1 or MCPCL1 security key will be able to perform end-of-day processing.
- End-of-Day processing must be fully completed before the Monthly Statistical Reports can be calculated and printed.
- If an End-of-Day Report (not shown) has been completed, the system will give you a breakdown of the kinds of patients each provider had for the day. For example: No. of No-Shows, No. of Walk-ins.
- You should select the End-of-Day Processing Report when there are no pending appointments or missing providers on the End-of-Day Processing screen.
- You should select the Criteria, Delinquent appointments only, to display the appointments with a Pending status and/or missing provider.
- The Delinquent End-of-Day Processing Report should be printed showing you appointments that need changes in appointment status or have missing provider names. This report will print out the total of appointments you will need to edit in the lower-lefthand corner, along with the exact appointment times to the right of the page.

**PAS****END-OF-DAY PROCESSING**

# **PAS: EMERGENCY ROOM PROCESSING**

## **Section 6 Transparencies**

**PAS: EMERGENCY ROOM PROCESSING**  
**Section 6. Transparencies**

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# 1. Sample SF558 Form

Personal Data - Privacy Act of 1974 (PL 93-579) Automated Version SF558

EMERGENCY CARE & TREATMENT - NAVY MTF DIVISION LOG NUMBER: 931220-00001

Arrival Date/Time: 20 Dec 1993@1545 3rd Party Payer: NO  
Trans to Hospital: AMBULANCE/MTF Time Seen:  
History Obtained From: PATIENT Category: EMERGENCY

Addr: 114 Lilac Lane HAMPTON, VA 23665 Phone: 535-7265  
Chief Complaint: CHEST PAINS, NUMBNESS IN RT ARM Sex: MALE Age: 33

VITAL SIGNS			Medications	Tetanus:
Time				Allergies:
SP-SY				MORPHINE, CODEINE,
BP-DI				TETRACYCLINE,
Pulse				TRICYCLIC ANTIDEPRESSAN,
Resp				VALPROATE DERIVATIVES,
Temp				VANCOMYCIN
WT-Ped				
Orders	Initis	Time		
ASSESSMENT/DIAGNOSIS				
----- DISPOSITION -----				
Home Full Duty				
Quarters				
24hrs 48hrs 72hrs				
Modified Duty Until:				
Day: Mon: Yr:				
Referred to:				
Emergency Today				
72 hours Routine				
Admitted to:				
Others:				
Condition Upon Release				
Improved Unchanged				
Deteriorated				
Release Time:				
Signature of Provider/Stamp:				

Instructions to Patient:

I HAVE RECEIVED AND UNDERSTAND MY DISCHARGE INSTRUCTIONS

20/234-98-7643 BRISTOL, HARRY USA ACTIVE DUTY  
01 Jan 1960 MALE W: 535-0985 H: 234-8712  
Loc: EMERGENCY ROOM Rank: MAJ D: 456-9823  
Spon: BRISTOL, HARRY RR: OUTPATIENT RECORD ROOM (A)  
SF558 Unit: 1912 COMMUNICATIONS G

PAS-SF558

# **PAS: EMERGENCY ROOM PROCESSING**

## **Appendix A Class Evaluation Forms**

# STUDENT ATTENDANCE AND PERFORMANCE SUMMARY

CLASS TITLE: \_\_\_\_\_ DATE: \_\_\_\_\_ SESSION # : \_\_\_\_\_

CLASSROOM LOCATION: \_\_\_\_\_ MEDICAL TREATMENT FACILITY: \_\_\_\_\_

INSTRUCTIONS: (See reverse side)

KEY:  Scheduled  Completed SP - Satisfactory Performance NR - Needs Remediation

STUDENT NAME/GRADE/RANK WORKCENTER (Please Print)		SSN	TRAINING SESSION				MASTER PRACTICE		COMMENTS
			1	2	3	4	SP	NR	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

Presenter's Signature

Date

Presenter's Name (Please Print)

Date

Instructions for use of the STUDENT ATTENDANCE AND PERFORMANCE SUMMARY form:

- a. Please print information except where noted otherwise.
- b. Complete the top portion of the form.
- c. Enter each student's name and other identifying data and indicate with a slash (/) that the student was scheduled to attend the class.
- d. Enter the students' Social Security Number.
- e. Enter the time(s) for the training sessions needed to complete the class.
- f. Document the students' performance on the Master Practice. If the class has more than one Master Practice, use additional form(s).
- g. Use the "Comments" section to document pertinent information regarding the students' attendance, interactions during the class, performance (strengths/areas of needed improvement), etc.
- h. Verify that the class was completed by entering a second slash (\).
- i. Sign and date the form and submit to the designated Training POC.

# CLASS CRITIQUE

CLASS TITLE: \_\_\_\_\_ Module #: \_\_\_\_\_

DATE: \_\_\_\_\_ SESSION #: \_\_\_\_\_ CLASSROOM LOCATION: \_\_\_\_\_

MEDICAL TREATMENT FACILITY: \_\_\_\_\_

INSTRUCTOR (Please Print): \_\_\_\_\_

PLEASE CIRCLE THE NUMBER OF YOUR CHOICE					
	Strongly Agree	Agree	Disagree	Strongly Disagree	Comments or N/A
<b>CLASS CONTENT</b>					
1. I found the class material well organized.	1	2	3	4	
2. There was adequate time allotted for instruction and practice.	1	2	3	4	
3. I understood the purpose and objectives of the class/module.	1	2	3	4	
<b>CLASS PRESENTATION</b>					
4. The instructor demonstrated a sound knowledge of the subject matter.	1	2	3	4	
5. The instructor responded positively to my learning needs.	1	2	3	4	
6. My questions were promptly answered.	1	2	3	4	
7. Visual aids helped me understand the class/module content.	1	2	3	4	
8. Class material projected on a screen was clearly visible.	1	2	3	4	
9. The class presentation and Practices adequately prepared me for the Master Practice.	1	2	3	4	
10. I understood the instructions for completing each Practice and Master Practice.	1	2	3	4	
11. I think that the handouts I received will be useful/helpful to me in the workcenter.	1	2	3	4	

▼ OVER ▼

## CLASS CRITIQUE (continued)

PLEASE CIRCLE THE NUMBER OF YOUR CHOICE					
	Strongly Agree	Agree	Disagree	Strongly Disagree	Comments or N/A
<b>LEARNING ENVIRONMENT</b>					
12. My terminal, printer, and any other hardware operated properly during the class.	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	
13. The Training Database/ Software worked properly with all functions taught.	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	
14. I found the classroom furnishings, lighting, and ventilation adequate.	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	
<b>GENERAL</b>					
15. Having completed this class/module, I feel that I now can successfully use CHCS to perform my job.	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	
	<b>All</b>	<b>Some</b>	<b>None</b>	<b>Not Applicable</b>	<b>Comments</b>
16. I attended the prerequisite training classes for this class/module.	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	
17. What aspects of this class were most beneficial?					
18. How could this class be improved?					
19. Additional comments:					

**PLEASE RETURN YOUR CLASS CRITIQUE TO THE PRESENTER  
BEFORE LEAVING THE CLASSROOM.**